Health Care Financing

Status Report

Research and Demonstrations in Health Care Financing

October 1983 Edition

Health Care Financing Administration

Health Care Financing

Status Report

The Office of Research and Demonstrations (ORD), Health Care Financing Administration (HCFA), directs more than 300 research, evaluation, and demonstration projects. A central focus is on program expenditures as they relate to reimbursement, coverage, eligibility, and management alternatives under Medicare and Medicaid. Study activity also examines program impact on beneficiary health status, access to services, utilization, and out-of-pocket expenditures. The behavior and economics of health care providers and the overall health care industry are also topics of investigation.

These activities are carried out by two major components—the Office of Research and the Office of Demonstrations and Evaluations. The Office of Research conducts and supports data collection efforts and research on health care providers, reimbursement, beneficiary behavior, and health care utilization. The Office of Demonstrations and Evaluations funds, manages, and evaluates pilot programs that test new ways of delivering and financing Medicare and Medicaid services.

This report provides basic information on active intramural and extramural projects in a brief format. These projects are used to access new methods and approaches for providing quality health care while containing costs, and they often provide the basis for making critical policy decisions on health care financing issues.

Projects are arranged according to ORD budget priority areas and subject categories. The synopsis on each project includes the title, project number, project period, name of contractor or grantee organization, Federal project officer with primary responsibility for the project, a brief description, and the status of the project as of June 30, 1983. When a project involves research and development funds, the total funding amount for the life of the project is included. Remaining extramural projects are being conducted with waivers that permit innovations to financing and delivery of health services under the Medicare and Medicaid programs.

This is the second edition of the *Status Report.* Updated editions will be produced on a semi-annual basis. The information presented should be of use to policy officials, health planners, and researchers in examining the range of research and demonstration activities that are undertaken by ORD and the implications of results and findings.

Health Care Financing

Status Report

Research and Demonstrations
in Health Care Financing

Office of Research and Demonstrations
Bryan R. Luce, Ph.D., Director
Steven A. Pelovitz, Deputy Director

Office of Research
Allen Dobson, Ph.D., Director

Office of Demonstrations and Evaluations
Barbara S. Cooper, Director

U.S. Department of Health and Human Services
Health Care Financing Administration
Office of Research and Demonstrations
Baltimore, Maryland
October 1983

Contents

HOSPITAL PAYMENT 1

Inpatient General 1
Valid and Reliable Measurement of Inappropriate Hospital Utilization Hospital Costs and the Reduction of Excess Hospital Capacity 1
Reducing Inappropriate Use of Inpatient Medical Surgical and Pediatric Services--Extension of the Appropriateness Evaluation Protocol 2
Public General Hospitals: Costs and Case Mix 2
Analysis of a Proposed Medicare Offset of Hospital Part B Losses With Surpluses Generated Under Part A 3
Analysis of Hospitals' Cost Center Overhead Distributions 4
Pediatric Appropriateness Evaluation Protocol Instrument 4

Outpatient 5
Physician and Other Ambulatory Services in Hospitals: Costs and Determinants 5
Relationship of Physician Medicaid Reimbursement in Private Practice and Hospital Outpatient Departments to Actual Costs of Providing Care 5
Comparison of Services by Hospital Outpatient Departments and Physicians' Offices 6
Case Mix and Resource Use in Hospital Emergency Room Settings 6
Development of a Case-Mix Based Reimbursement Method for Hospital Outpatient Departments and Free-Standing Clinics 7
Analysis of Hospital Outpatient Costs and the Ratio of Outpatient Costs to Charges 7

Prospective Payment 8
Finger Lakes Area Hospitals' Corporation 8
National Hospital Rate-Setting Study 9
Incentive Prospective Payment System for Hospitals Through Fiscal Intermediaries (Massachusetts) 10
Rochester Area Hospitals' Corporation 10
Prospective Reimbursement System Based on Patient Case-Mix for New Jersey Hospitals 11
Proposal for the Development of a Hospital Reimbursement Methodology for New York State for the 1980's 12
Prospective Payment System for Acute and Chronic Care Hospitals in Maryland 12

Case Mix 13
An Examination of the Case-Mix Length of Stay, Costs, and Reimbursement of Rural Hospitals 13
Measuring the Cost of Case Mix Using Patient Management Algorithms 13

Capital 14
Medicare-Medicaid Payment Policies and Capital Formation 14
Analysis of Interest Income on Funded Depreciation 15

Data Development and Analyses 15
Automated Hospital Information Systems: Development of Evaluation Methods 15
Data for Hospital Cost Monitoring and Analysis of Hospital Costs 16
Statistical and Analytical Services to Support Provider Reimbursement Studies 16

Financially Troubled Hospitals 17
Bedford-Stuyvesant/Crown Heights Demonstration Project 17
Metropolitan Comprehensive Care Program: A Health Systems Organization Demonstration 17
Alternative Methodologies for Reimbursement and Delivery of Health Care Services to Inner City Poor 18
Strategies to Improve the Financial Viability of the Urban Hospital 19
A Proposal to Relieve Financial Distress at a Congested Urban Medical Center 19

Other Hospital 20
Allocation of Resources Under the Budget Constraints Imposed by the British National Health Service 20

PHYSICIAN PAYMENT 21

Data Development and Analyses 21
Anaylsis of Survey Data and Physician Practice Costs and Income: Physician Earnings and Return to Medical Training and Specialization 21
Alternative Methods for Describing Physicians' Services Performed and Billed 21
Analysis of Physician Pricing Behavior, Third Party Administrative Practices 22
Aspects of Physician Behavior in Medicare and Medicaid 22
Alternative Methods for Developing a Relative Value Scale of Physician Fees 23
Costs, Outcomes, and Competition in the End-Stage Renal Disease Program 23
Pricing Behavior of Pennsylvania Physicians Since 1970 24
Survey of Physicians' Practice Costs and Incomes: Redesign and Implementation 24
Assignment Rates Revisited 25
Prospective Payment of Physicians 25

Other Physician Payment 25
Physician Reimbursement and Continuing Care under Medicaid Suffolk County, New York 25
Studies in Physician Reimbursement 26
Impact of Physician Supply and Regulation on Physician Fees and Utilization of Services 26

LONG-TERM CARE 28

Skilled Nursing Facility Prospective Payment 28
Alternative Nursing Home Reimbursement Systems for Medicare 28
New York State Capitation Payment System for Long-Term Care 28
West Virginia Long-Term Care, Quality-Cost Control System 29
Longitudinal Study of the Impact of Prospective Reimbursement Under Medicaid on Nursing Home Care in Maine 29

Channeling 30
Evaluation of Coordinated Community Oriented Long-Term Care Demonstration 30
National Long-Term Care Channeling Demonstrations 30

Community-Based Care 33
Medicare/Medicaid Hospice Demonstrations 33
State Medicaid Hospice Demonstrations 37
National Hospice Study 39
Deinstitutionalizaton of the Chronically Mentally Ill 40
A Model Addressing the Residential Needs of the Chronically Mentally Ill 40
Effective and Efficient Community Support Services for the Chronically Mentally Ill 40
Cost-Effective Community Alternatives to Institutionalization of the Chronically Mentally Ill 40
Cost-Effective Comprehensive Community Residential Treatment of the Chronically Mentally Ill 40
Housing and Urban Development Demonstration Program for the Chronically Mentally Ill 41
Cost Effective Community Alternatives to Deinstitutionalization of the Chronically Mentally Ill 41
Services in HUD Transitional Housing for Chronically Mentally Ill 41
Deinstitutionalization of the Chronically Mentally Disabled, Cost-Effective Community Alternatives 41
Housing and Urban Development Demonstration Program for the Chronically Mentally Ill 41
Community Alternatives to the Instutionalization of the Chronically Mentally Ill 41
Cost-Effective Community Residential Treatment for the Mentally Ill 42
Highline Independent Apartment Living Project 42
On Lok Community Care Organization for Dependent Adults 42
Study of the Virginia Pre-Admission Screening Program 42
Social Health Maintenance Organization Project for Long-Term Care 43
Multipurpose Senior Services Project 43
Demonstration of Community-Wide Alternative Long-Term Care Model 44
Continued Demonstration of a Long-Term Care Center Through Inclusion and Expansion of Title XVIII 44
Home Services for Functionally Disabled Adults 45
New York State's Long-Term Home Health Care Program 45
Evaluation of New York State's Long-Term Home Health Care Program 46
South Carolina Community Long-Term Care Project 46
Modifications of the Texas System of Care for the Elderly: Alternatives to the Institutionalized Aged 47

Long-Term Care Demonstration Project of North San Diego County 47
Delivery of Medical and Social Services to the Homebound Elderly: A Demonstration of Intersystem Coordination 48
Long-Term Care Demonstration Design and Development 48
Ancillary Community Care Services: A Health Care System for Chronically Impaired Elderly Persons 49

Swing Bed 49
Reducing Acute Care Costs 49

Quality 50
Improving New York State's Nursing Home Quality Assurance Program 50
Survey by Exception 50
Quality Assurance Sampling: A Statistical Quality-Control Approach to Inspection of Care 51
Evaluation of Three-State Demonstration in Nursing Home Quality Assurance 51

Data Development and Analyses 52
Interagency Agreement for Long-Term Care Survey of Individuals in Households 52
Long-Term Care Residential Services for Developmentally Disabled People 52

Home Health Aides 54
A Plan for Employing AFDC Recipients as Homemaker/Home Health Aides to Provide Alternatives to Long-Term Care 54
Preventacare: An Alternative to Institutionalization 54
AFDC Homemaker/Home Health Aide Demonstration Project 54
New York State AFDC Homemaker/Home Health Aide Demonstration 55
Employment Opportunity for AFDC Recipients in the Homemaker/Home Health Aide Field 55
Homemaker/Home Health Aide Project 55
AFDC Recipients as Providers of Services to Aged and Disabled 55
Design Development and Evaluation of the AFDC Homemaker/Home Health Aide Demonstration Project 55

Other Long-Term Care 56
Bioactuarial Estimates and Forecasts of Health Care Needs and Disability 56
Development of Patient Classification of Resource Utilization in Long-Term Care 56
Impact of State Discretionary Policies 57
Comparison of the Cost and Quality of Home Health and Nursing Home Care 57
Pursuit of Institutional Alternatives 58
Encouraging Appropriate Care for the Chronically Ill Elderly: A Controlled Experiment to Evaluate the Impacts of Incentive Payments on Nursing Home Admissions, Discharges, Case-Mix, Care, Outcomes, and Costs 58
Effects of Alternative Family Support Strategies 59
Analysis of Long-Term Care Payment Systems 59
Comparison by State of SNF/ICF Types: Beds, Staffing, Utilization, and Ownership 60

ALTERNATIVE PAYMENT SYSTEMS 61

Competition 61
A Demonstration of Cost Control and Patient Satisfaction Resulting from the Relaxation of the Maximum Public Enrollment Rule for HMO's 61
Competitive Bidding for Clinical Laboratory Services 61
Evaluation of Health Maintenance Organization (HMO) Capitation Demonstrations 62
Evaluation of the Arizona Health Care Cost Containment System 63

Medicare Competition Projects: 64
Medicare Prospective Capitation Demonstration Project 64
Enrollment of Medicare Beneficiaries Under a Unique Intra-Health Maintenance Organization Competition Model 64
Medicare Competition Demonstrations 65
Development, Implementation, and Management of Medicare Competition Demonstrations 77
Alternative Models for Prepaid Capitation of Health Care Services for Medicare Beneficiaries in the Twin Cities Area 78
Alternative Models for Prepaid Capitation Financing of Health Care Services for Medicare 79
Alternative Models for Prepaid Capitation of Health Care Services for Medicare Recipients 79
Alternate Models for Prepaid Capitation of Health Care Services for Medicare Recipients 80

Medicaid Competition Projects: 81
Santa Barbara Health Initiative 81
Monterey County Health Intitiative 81
Florida Alternative Health Plan Project 82
Medicaid Voucher Demonstration 83
Arizona Health Care Cost-Containment System 83
Missouri Medicaid Prepaid Health Demonstration Project 84
Statewide Medicaid Competition Demonstration 84
Monroe County MediCap Plan 85
Competitive Managed Health Plans for AFDC Medicaid Recipients 86
Health Care Alternatives Within Title XIX: Evaluation of Alternative Reimbursement Methods to Providers of Primary Care Medical Services 86
Waiver Only Competition Project for Southern California, Illinois, Indiana, and Texas 87
Medicare Beneficiary Decisionmaking About Health Plans 87

Health Maintenance Organization Studies 88
Physicians' Use of Medical Care Resources in a Prepaid Group Practice Health Maintenance Organization 88
Health Status Measure for Adjusting Health Maintenance Organization Rates of Medicare Beneficiaries 88
Adjusted Average Per Capita Costs 89
Research to Improve the Adjusted Average Per Capita Cost Formula to Pay Health Maintenance Organizations 90

Former Disability as an Adjustment Factor for the Adjusted Average Per Capita Costs 90
Use of Prior Utilization for Prospective Payment of Health Maintenance Organizations 91

Other Alternative Payment Systems 91
Massachusetts Dental Case Management 91

PROGRAM ANALYSIS AND EVALUATION 93

National Medical Care Utilization and Expenditure Survey 93
Analysis of NMCUES Data

Title XIX Data Development 94
Acquisition and Analysis of State Medicaid Data (Tape-to-Tape) 94
Analysis of Information and Assistance Needs of State Medicaid Agencies 94
Who's on Medicaid: A Comparison of Available Data 95

Medicare Fixed-Price Contracting 95
Evaluation of Part B Fixed-Price Medicare Contracts 95
Study of the Quality and Effectiveness of Experimental Fixed-Price Medicare Part A Intermediary Contracting 96

Program Management 96
Methodology for Performing Computer-Assisted Simulations of the Effects of Changes in Medical Procedural Terminology Systems 96
Proposal for the Development of a Medicaid Fraud and Abuse Detection Methodology 97
State Medicaid Information Center Project 98
Intergovernmental Health Policy Project 99

Reporting 99
Assessment and Redesign of Health Maintenance Organization (HMO) Reporting Requirements Project 99

Policy Centers 100
Program in Health Care Policy and Financing at Northwestern University 100
Health Care Financing and Regulation Center at Brandeis University Health Policy Consortium 101

Program Analysis 102
An Evaluation of Equity Under the Medicare Program 102
Medicaid Programmatic Characteristics Research Study 103
Medicaid Cost Containment and Urban Medical Care 104
Trends in Medicaid Program Expenditures and Changes in Medicaid Program Characteristics 104
Use of Medicare Services by Disabled Enrollees Under 65 Years of Age 104
Use of Services by the Dually Entitled 105
Impact of Deductibles and Coinsurance on Medicare Enrollees 105

Post-Surgical Mortality Among the Aged for Common Operations 106
Studies of Medicare Use Before Death 106
Study of High Cost Infants Under Medicaid 107
Changes in the Distribution of Medicare Expenditures 107
Medicare/Medicaid Data Book 107
Program Statistics Series Reports 108
Program Evaluation 109
State Mortality Statistics 109
Time Series Variation Rate Study of Medical Care Problem Areas Identified and Affected by PSRO MCE Studies 109
Medicaid Short-Term Evaluation 110
State Legislative Resource and Information Center on Health Care Financing 110

COVERAGE 112

End-Stage Renal Disease 112
National Kidney Dialysis and Kidney Transplantation Study 112
Encouraging Cost-Effective Treatment of End-Stage Renal Disease 113
Physicians Who Care for End-Stage Renal Disease Patients: A National Study of Their Practices, Patients, and Patient Care 114
Evaluation of Reimbursing Home Dialysis Aide Demonstration 114
Design of a Demonstration and Assessment of Competitive Health Insurance Proposals in the End-Stage Renal Disease Program 115
Developing Incentive Systems to Increase the Supply of Cadaveric Kidneys for Transplants 116
Case-Mix Differences Between End-Stage Renal Disease Facilities 116
Kidney Procurement in the United States 117
Medicare End-Stage Renal Disease Experience 117
Study of Unentitled End-Stage Renal Disease Patients 118

Urban Clinics 119
Urban Health Clinics Demonstration 119
Evaluation of the Urban Health Clinics Demonstration 119

Technology Costs 120
Proposal to Develop a Plan for a Private/Public Sector Entity for Assessing Technology in Medical Care 120

Clinical Social Worker 120
Medicare Clinical Social Worker Demonstration 120

Other Coverage 121
State Policies and Procedures for Determining Medicaid Coverage for Newborns 121
Reexamination of the 44 Free-standing Emergency Centers or Emergicenters 121
Study of Medicare Funded Health Transplants 122
Determinants of Current and Future Expenditures on Durable Medical Equipment 123
Medicare Mental Health Demonstration 124
Evaluation of the Medicare Mental Health Demonstration 124

Study of the Impact of Rural Health Clinics on the Use of Inpatient Hospital Services 125
Study to Evaluate the Impact of Rural Health Clinic Services 125
California State Copayment Project 126
Medigap Study of Comparative Effectiveness of State Regulations 126
Technology Assessment for Insurance Coverage Decisions 127

Alcoholism Services Demonstration Projects: 128
Alcoholism Services under Medicaid: Connecticut Demonstration 128
Alcoholism Services under Medicare and Medicaid: Illinois Demonstration 128
Alcoholism Services under Medicare and Medicaid: Michigan Demonstration 129
Alcoholism Services under Medicare and Medicaid: New Jersey Demonstration 129
Alcoholism Services under Medicare and Medicaid: New York Demonstration 129
Alcoholism Services under Medicare: Oklahoma Demonstration 130
Evaluation of the Alcoholism Services Demonstration 130
Obstetrical Access Pilot Project 131
Evaluation of Obstetrical Access Pilot Project 131
Foot Care Coverage Study 132
Registered Dietitians in Home Care 132
Home Respiratory Therapy Services 133
Medicare Health Maintenance Organization Additional Benefits 133

PREVENTION 134

Child Health 134
Health Care Services for Children Under Medicaid
Prenatal Care and Its Relationship to Medicaid Costs 134

Other Prevention 135
Municipal Health Services Program 135
Evaluation of Municipal Health Services Program 136
Quality and Effectiveness of Preventive Medical Care 136
Evaluation of the Impact of Second Opinions for Elective Surgery 137
Cooperative Health Education Project 137
Prevention of Future Utilization of Health and Long-Term Care Services 138
Trends in Pediatrician Participation in State Medicaid Programs 138

INDEX TO CONGRESSIONALLY MANDATED STUDIES 140

HOSPITAL PAYMENT

Inpatient General

Valid and Reliable Measurement of Inappropriate Hospital Utilization

Project No.: HCFA 500-80-0053
Period: June 1980 - September 1983
Funding: $ 950,406
Contractor: SysteMetrics, Inc.
Bethesda, Md.
Project Officer: Sherry A. Terrell
Division of Beneficiary Studies

Description: The purpose of this project is to study inefficient acute care hospital utilization. The study has two components:

- The development of a methodology for measuring inappropriate hospital utilization.

- The application of the method in a national study to estimate the magnitude of inappropriate utilization and to identify likely causal factors. A (patient) chart review methodology was applied in 253 general acute care hospitals across the United States. Estimates of inappropriate admissions and days of care are being developed.

Status: This project is nearing completion. All developmental activity and field work are complete. A data set has been developed and data analysis is in progress. A final report is in preparation and is expected by late 1983.

Hospital Costs and the Reduction of Excess Hospital Capacity

Project No.: 95-P-97526/5-02
Period: December 1979 - March 1984
Funding: $ 270,000
Grantee: Michigan Office of Health and Medical Affairs
Lansing, Mich.
Project Officer: Joe Cramer
Division of Hospital Experimentation

Description: This project grew out of concerns of labor and industry organizations involved in paying for medical care. By eliminating excess hospital beds, health care costs could be reduced. A Governor's task force was formed to address the financial, legal, and employment-related issues involved in hospital closures. Legislation was passed to require the development of bed-reduction plans. It is anticipated that 3,800 acute care hospital beds will be eliminated over the life of the program. Under the demonstration, the Michigan Hospital Capacity Reduction Corporation will review proposals from hospitals and approve specific reimbursement waivers related to capacity reduction activities. All third-party payers are expected to participate.

Status: Six health systems agencies with excess beds developed hospital-specific, bed-reduction plans that are updated on an ongoing basis. A Hospital Capacity Reduction Corporation was established in January 1981 to facilitate hospital capacity reduction. The Health Care Financing Administration is currently reviewing Michigan's latest request for waivers of selected Medicare reimbursement policies to facilitate hospital capacity reduction. The waiver request is in the final stages of review. The details for implementation, including coordination of the terms of the waiver with the new prospective payment system for Medicare must still be resolved. In consideration of the delay, the Health Care Financing Administration recently gave Michigan a no-cost extension of their second year grant period to September 30, 1983.

Reducing Inappropriate Use of Inpatient Medical Surgical and Pediatric Services--Extension of the Appropriateness Evaluation Protocol

Project No.: 18-P-98317/1-01
Period: May 1983 - January 1985
Grantee: University Hospital, Inc.
Boston, Mass.
Project Officer: Sherry A. Terrell
Division of Beneficiary Studies

Description: The purpose of this grant is to revise the Appropriateness Evaluation Protocol (AEP) to deal with two concerns: the problem of surgical admissions which should be performed on an outpatient basis and the problem of indications for performance of surgical procedures. The grantee will also conduct a formal experimental trial of the effectiveness of educational feedback of AEP results to hospital administrators and physicians upon lowering levels of inappropriateness.

Status: This project is in its developmental phase. The first 3 months are to be spent recruiting study participants, negotiating with review organizations, finalizing research design, and sampling procedure, and project startup.

Public General Hospitals: Costs and Case Mix

Funding: Intramural
Project Director: J. Michael Fitzmaurice
Division of Reimbursement Studies

Description: Public general hospitals (PGH's) are often the health care "providers of last resort" for patients who cannot afford to pay for their hospital care and are not covered under Medicaid. Because of this special role, public general hospitals frequently incur costs which do not receive direct reimbursement for services provided to many of their (poor) patients. Tax-financed subsidies often come from the State or local governments that have jurisdiction over these hospitals, but the hospitals' patient care costs may not be fully covered by these subsidies. This leads to public hospital expenses being greater than revenues and to reduced access to hospital care for part of the population. In the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), the Congress directed the Secretary, Department of Health and Human Services, to consider the "special needs" of hospitals "that serve a significantly disproportionate number of patients who have low income or are entitled to benefits" under Medicare in the application of the Section 101 total operating expense per case limits. In addition

to TEFRA, there is also a concern over the level of rates with which PGH's would be faced under the Medicare prospective payment system. As part of considering the "special needs" of PGH's, this study will examine the Medicare cost reports of public general hospitals to determine if their costs are higher than the costs of other short-term general community hospitals and other hospitals with the same characteristics as PGH's, other than public ownership. The Medicare case-mix indices of these hospitals and the number of exceptionally-long-stay cases will also be examined to see if there is any evidence that PGH patients have measurably higher case complexities.

Status: The data base for this study is the 1980 Hospital Medicare Cost Report File, the 1980 Medicare Case-Mix Index File, and the 1981 Office of Civil Rights Hospitals Survey. These files have been linked and edited. Analysis of this data has begun and a draft report of this study is expected to be completed by December 1983.

Analysis of a Proposed Medicare Offset of Hospital Part B Losses with Surpluses Generated under Part A

Funding: Intramural
Project Director: J. Michael Fitzmaurice
Division of Reimbursement Studies

Description: This study examines the potential effects of a proposal for eliminating two regulatory adjustments:

- The provision for aggregate calculation of the lesser of costs or charges between inpatient (Part A) and outpatient (Part B) hospital services (rather than keeping the calculations separate between Part A and Part B hospital services).

- The provision allowing providers to carry forward unreimbursed costs (any negative sum of Part A plus Part B, cost minus charge differences) to subsequent years to a time when costs exceed charges.

Status: This study reveals that, in 1980, 20 percent (196) of a sample of 984 hospitals used an excess of inpatient charges over costs to offset outpatient losses (charges less than costs). The range of these offsets per hospital was from $125 to $4.5 million. For the sample, the estimated cost to the Medicare program in 1980 was $28 million. The groups of hospitals with the largest mean offsets were those having a larger number of beds, nonprofit or government type of control, a location out of the North Central region, a location in standard metropolitan statistical areas, and teaching status. A final report was received April 1983.

Analysis of Hospitals' Cost Center Overhead Distributions

Funding: Intramural
Project Director: J. Michael Fitzmaurice
Division of Reimbursement Studies

Description: This study is a response to a potential proposal to reduce the reporting burden of the Medicare cost report by eliminating the step-down allocation of hospital costs. If the overhead expenses of all hospital cost centers can be distributed to the revenue centers in the same proportions as total revenue (charges) is distributed among the revenue centers, substantial savings can be achieved by eliminating much of the step-down allocation of costs. This elimination of the step-down allocation of costs could substantially reduce the annual reporting burden of the Medicare cost report for hospitals.

Status: Research is presented on whether or not overhead expenses are distributed across departments in the same proportion to total overhead costs as departmental revenues are to total departmental revenues. This study finds that overhead costs are not allocated across revenue centers in the same proportions as the ratio of revenue center charges to total charges. Further, it is demonstrated that hospital charges are not, in general, set equal to revenue center costs plus a percentage of these costs. That is, departmental costs are not marked up by a constant percentage to derive departmental charges. Average revenue center markup rates across hospitals show strong variation, ranging from -29 percent for outpatient clinics to 252 percent for electrocardiology.

Pediatric Appropriateness Evaluation Protocol Instrument

Funding: Brandeis University Health Policy Consortium
(See page 101)
Project Officer: Sherry A. Terrell
Division of Beneficiary Studies

Description: One of the projects conducted by the University Health Policy Consortium was to adapt the Appropriateness Evaluation Protocol (AEP), originally designed for review of adult medical and surgical admissions and days of care, to the needs for pediatric review. The principle instrument revisions made were to strengthen the admission criteria to account for special pediatric admission problems such as failure to thrive and child abuse. In addition, the criteria for an appropriate day in the hospital, although similar to those utilized for adults, were modified to account for physiologic differences between adults and children. As an example, normal values for lab tests, blood pressure, and temperatures were modified to reflect pediatric norms. It should be noted that the instrument applies to children 2-15 years of age and is not intended for review of neonatal care.

Status: Following instrument revision, the Policy Center has conducted a set of methodological trials to assess the reliability and utility of the AEP/PED. Currently, a field trial is being completed using the AEP/PED on Medicaid pediatric admissions in the Metropolitan Boston area.

The Health Care Financing Administration expects to receive the following products: the AEP/PED 83 instrument, training manual instructions, and a final report December 1983.

Outpatient

Physician and Other Ambulatory Services in Hospitals: Costs and Determinants

Project No.: 18-P-97880/5
Period: April 1981 - September 1983
Funding: $ 348,318
Grantee: American Hospital Association
Chicago, Ill.
Project Officer: James Cantwell
Division of Reimbursement Studies

Description: This ambulatory care project involves the collection and analysis of a large and significant data set that is expected to be the first in a recurring survey of hospital ambulatory care. The analysis is expected to provide a context for better understanding of the costs of hospital-based ambulatory care. The data will facilitate describing and monitoring costs of services in hospital outpatient departments.

Status: The American Hospital Association's first major submission under this grant was the refined analytical design submitted in October 1981. The survey design required several iterations because outpatient department cost data is not typically recorded in disaggregate detail by most hospitals. Surveying began in November 1982. Special followup efforts to enhance response rates have been prepared for public hospitals, urban hospitals, teaching hospitals, and hospitals with more than 300 beds.

Relationship of Physician Medicaid Reimbursement in Private Practice and Hospital Outpatient Departments to Actual Costs of Providing Care

Project No.: 18-P-97905/1-02
Period: January 1981 - January 1983
Funding: $ 224,022
Grantee: Brandeis University
Florence Heller Graduate School
Waltham, Mass.
Project Officer: John T. Petrie
Division of Reimbursement Studies

Description: This study compares the mix and cost of patients treated in hospital outpatient departments with those treated in private physicians' offices. It attempts to determine the extent to which presenting diagnoses differ in these settings and the extent to which those differences generate costs in one type of setting that substantially differ from those in others.

Status: The project has been completed and the Health Care Financing Administration (HCFA) published an article in the Health Care Financing Review, Vol. 4, No. 1, September 1982. HCFA received the final report in May 1983. Among the principal findings are:

- Hospital outpatient department (OPD) patients do not appear to be very much sicker than do patients of private practitioners.
- More than half of all hospital OPD visits involve a social problem.
- Overhead from the inpatient side of the hospital is not a major cause of the disparity in cost between a visit to an OPD and to a private physician. Rather, the major cause is the cost of additional personnel per patient visit in the large hospital OPD.
- The cost of ancillary services does not appear to be higher in the hospital OPD.

Comparison of Services by Hospital Outpatient Departments and Physicians' Offices

Project No.: 500-82-0018
Period: June 1982 - February 1983
Funding: $ 177,872
Contractor: Mandex, Inc.
Vienna, Va.
Project Officer: Benson Dutton
Division of Reimbursement Studies

Description: Title XXI, Section 2142 of Public Law 97-35 (The Omnibus Budget Reconciliation Act of 1981), instructs the Secretary to issue regulations that limit reimbursements to hospitals for outpatient services. In addition, the regulations must limit reasonable costs for outpatient services to reasonable charges for similar services delivered by area physicians in their offices. The Office of Research and Demonstrations awarded a contract to Mandex, Inc., to develop a method for complying with Section 2142. Mandex proposed using data from four States as a basis for their project. The States (Maryland, New Jersey, South Carolina, and Florida) present a cross-section of intermediary and carrier operations. Intermediaries act as fiscal agents for Medicare Part A (hospital insurance) services. Carriers reimburse physicians and beneficiaries for Part B (supplementary medical insurance) services.

Status: The project has been completed and a final report delivered. The report described services provided by physicians in hospital and outpatient departments which are in most, in some, or in very few instances similar to services provided in physicians offices. One significant finding was that physicians' charges were lower for outpatient services delivered in a hospital setting than for identical services delivered in an office.

Case Mix and Resource Use in Hospital Emergency Room Settings

Project No.: 18-P-98310/9-01
Period: March 1983 - March 1985
Funding: $ 440,193
Grantee: University of California
School of Public Health
Los Angeles, Calif.
Project Officer: John T. Petrie
Division of Reimbursement Studies

Description: The purpose of this study is to develop a patient classification scheme and case-based cost control system for hospital emergency room settings. Such a system might provide the Health Care Financing Administration (HCFA) with the foundation for reimbursing hospitals on a case-mix basis for the treatment of emergency room patients. This project will also study overall potential for case-based reimbursement for all components of hospital-based ambulatory care. The grantee will address two main issues important to HCFA in understanding and controling hospital costs:

- The growth in the use of hospital-based ambulatory care services and how they relate to inpatient hospital services.
- The creation of fair and equitable incentives for cost containment.

Status: This project was initiated March 31, 1983.

Development of a Case-Mix Based Reimbursement Method for Hospital Outpatient Departments and Free-Standing Clinics

Project No.: 18-P-98300/1-02
Period: March 1983 - March 1986
Funding: $ 790,108
Grantee: Brandeis University
Waltham, Mass.
Project Officer: John T. Petrie
Division of Reimbursement Studies

Description: The purpose of this grant is to provide accurate case-mix and patient socioeconomic data about visits to hospital outpatient departments (OPD's) and free-standing clinics. The grantee will develop a case-mix based methodology, similar to the diagnosis-related groups (DRG's), which the Health Care Financing Administration can use to reimburse hospital OPD's. They will provide policymakers with information on the special situation of hospital OPD reimbursement, and investigate why the same visit to a hospital OPD can cost twice as much as a visit to a physician in private practice. Their case-mix reimbursement system will be able to compare OPD's with each other with respect to medical and social differences in case load and then will allow OPD's to be reimbursed the same amount for patients of the same type.

Status: This project was initiated March 31, 1983.

Analysis of Hospital Outpatient Costs and the Ratio of Outpatient Costs to Charges

Funding: Intramural
Project Director: J. Michael Fitzmaurice
Division of Reimbursement Studies

Description: A model has been developed in the Health Care Financing Administration (Bureau of Program Operations and Health Standards and Quality

Bureau) to assess the savings that occur from increased scrutiny by Medicare hospital financial intermediaries of hospitals which may make unwarranted outpatient billing for payment of services provided to hospital inpatients in the outpatient department. This model requires knowledge of the relationship of outpatient costs to charges in order to translate the savings across hospitals, which are recorded in terms of billed charges, into Medicare program costs.

Status: The relationship between hospital outpatient costs and charges is examined by this study to determine if extensive variation exists across hospitals and if this variation can be explained by the characteristics of the hospitals. The study's results are that variation was not extensive in the 1980 sample of hospitals under analysis. A regression analysis to investigate this variation explains only 6 percent of the variation, however, it does reveal some significant findings. The following hospital characteristics are associated with higher ratios:

- Nonprofit hospital type of control (higher by .077).
- Location in the South (higher by .064) and the West (higher by .056), relative to the North Central Region.
- Teaching hospital status (higher by .082).
- Number of beds (each additional hospital bed increased the ratio by .00009).

Prospective Payment

Finger Lakes Area Hospitals' Corporation

Project No.:	95-P-97877/2-01
Period:	January 1981 - December 1983
Grantee:	Finger Lakes Area Hospitals' Corporation Geneva, N.Y.
Project Officer:	Vic McVicker Division of Hospital Experimentation

Description: The Finger Lakes Area Hospitals' Corporation (FLAHC) is a test of whether an areawide budget system will be effective in controlling hospital costs in a rural area and whether local decisionmaking can effectively allocate financial resources between hospitals to cover the cost of new services. This 3-year project, which includes all third-party payers (Medicare, Medicaid, and Blue Cross), was initiated January 1981, and includes eight hospitals in the rural Finger Lakes area of New York. The FLAHC payment program places an upper limit or cap on the total revenue paid to the community's hospitals for all patient care. Each participating hospital's revenue for 3 years is guaranteed at a base level, calculated primarily from the hospital's 1979 costs, trended forward to reflect inflation. In addition, a 2-percent contingency fund is

administered by FLAHC to pay for increased hospital services and new and improved medical technology, and to provide working capital for participating hospitals. The contract has an option to be extended for 2 additional years.

Status: Changes in utilization and cost levels of the FLAHC hospitals during the first year of the project were compared with the corresponding changes for two sets of comparable hospitals, one group located in the Syracuse area and the other in Northeastern New York State. From 1980 to 1981, the inpatient cost per day rose 13.3 percent in FLAHC, compared with 13.5 percent for the Syracuse peer group, and 15.0 percent for the Northeastern peer group. Patient discharges dropped 6.1 percent in the FLAHC area, compared with drops of 1.9 percent for the Syracuse peer group and 1.1 percent for the Northeastern peer group. The most relevant cost measure--total inpatient cost--rose 11.4 percent in FLAHC, compared with 16.6 percent for the Syracuse peer group and 14.5 percent for the Northeastern peer group. Other measures of inpatient utilization and cost performance also showed a beneficial effect.

National Hospital Rate-Setting Study

Project No.: 500-78-0036
Period: August 1978 - August 1983
Funding: $ 4,462,237
Contractor: Abt Associates, Inc.
Cambridge, Mass.
Project Officer: Richard Yaffe
Evaluative Studies Staff

Description: This is the evaluation of the impact of 15 hospital prospective reimbursement programs from 1970 to 1979. The study focuses on the following eight areas:

- Cost/Revenue/Financial Viability
- Volume and Composition of Services
- Staffing and Labor Cost
- Quality of Care and Ancillary Intensity
- Capital Formation and Closure/Merge Rates
- Organization and Management
- Accessibility of Care
- Systemwide Cost and Utilization

Status: The final results for each of the above listed areas will be available by December 1983.

Incentive Prospective Payment System for Hospitals Through Fiscal Intermediaries (Massachusetts)

Project No.: 95-P-98199/1-01
Period: September 1982 - September 1986
Grantee: Massachusetts Hospital Association
Burlington, Mass.
Project Officer: Diane L. Rogler
Division of Hospital Experimentation

Description: This is a Statewide all payer prospective hospital reimbursement project proposed to Medicare by the Massachusetts Hospital Association and administered by Medicare's fiscal intermediaries. The methodology utilizes a "maximum allowable cost" developed from 1981 base year costs which are adjusted annually for inflation, volume changes, and certain other exceptions. Each year the amount paid to hospitals is reduced by a 2-percent productivity factor. The Massachusetts Rate-Setting Commission approves each hospital's gross patient service revenue and provides an oversight function. The waiver award was made with the condition that Medicare expenditures in Massachusetts be capped at 1.5 percent less than the national average rate of increase. If total hospital costs rise less than that amount, the hospitals will share in half of the savings.

Status: Implementation of the project began October 1, 1982. Currently, charges and payments from Blue Cross, Medicare, and Medicaid are based on the maximum allowable cost methodology.

Rochester Area Hospitals' Corporation

Project No.: 95-P-97501/2-02
Period: January 1980 - December 1984
Grantees: State of New York
Albany, N.Y.
Rochester Area Hospitals' Corporation
Rochester, N.Y.
Project Officer: Vic McVicker
Division of Hospital Experimentation

Description: The Rochester Area Hospitals' Corporation (RAHC) Hospital Experimental Payment Program is a test of whether an areawide budget system will be effective in controlling hospital costs in a metropolitan area and whether local decisionmaking can effectively allocate financial resources between hospitals to cover the cost of new services. This 5-year project which includes all third-party payers (Medicare, Medicaid, and Blue Cross) was initiated January 1, 1980, and includes nine hospitals in the Rochester area of New York. The Hospital Experimental Payment program places an upper limit or cap on the total revenue paid to the community's hospitals for all patient care. Each participating hospital's revenue for 5 years is guaranteed at a base level, calculated primarily from the hospital's 1978 costs, trended forward to reflect inflation. In addition, a 2-percent contingency fund is administered by RAHC to pay for increased hospital services and new and improved medical technology, and to provide working capital for participating hospitals.

Status: Based on an assessment of the first 3 years of operation, the hospitals and payers agreed to maintain the system for the entire 5-year test. As part of this asessment, a comparison of cost from 1978 to 1981 was made between Rochester and comparison hospitals in Buffalo and Syracuse.

- Cost per patient day increased 32.2 percent in Rochester, 45.8 percent in Buffalo, and 46.1 percent in Syracuse.
- Cost per admission increased 39.1 percent in Rochester, 44.7 percent in Buffalo, and 49 percent in Syracuse.
- Cost per emergency department visit increased 41 percent in Rochester, 67 percent in Buffalo, and 61 percent in Syracuse.
- Cost per outpatient clinic visit increased 20.5 percent in Rochester, 32 percent in Buffalo, and 23.8 percent in Syracuse.

The latest data on total Medicare hospital payments in Rochester show rates of increases of 11.9, 10.8, and 9.0 percents in 1980, 1981, and 1982, far below the national average growth in Medicare hospital payments.

Prospective Reimbursement System Based on Patient Case-Mix for New Jersey Hospitals

Project No.:	600-77-0022
Period:	December 1976 - December 1983
Funding:	$ 4,912,802
Contractor:	New Jersey State Department of Health Trenton, N.J.
Project Officer:	Cynthia K. Mason Division of Hospital Experimentation

Description: This project is testing a prospective payment system based upon diagnosis-related groups (DRG's). Each DRG contains diagnoses that require similar levels of resource consumption. Hospitals retain any savings if costs are less than the DRG rates, but they assume liability if expenditures are greater. All general acute care hospitals in the State are required to participate and the system is applicable to all patients as well as third-party payers.

Status: All general acute care hospitals were phased into the system over a 3-year period that ended December 1, 1982. Over the course of the demonstration, the State has been successful in overcoming many of the billing and data problems associated with a per-case payment system and indications are that the system has had a positive effect upon the management of hospital resources in the State.

Proposal for the Development of a Hospital Reimbursement Methodology for New York State for the 1980's

Project No.: 95-P-98216/2-01
Period: January 1983 - December 1985
Grantee: State of New York Department of Health
Albany, N.Y.
Project Officer: Joe Cramer
Division of Hospital Experimentation

Description: The 3-year project is a test of a prospective per diem payment system for all payers in the State. Rates are determined using 1981 costs as the base. Base year allowable costs are calculated through the use of peer group comparisons with ceilings on ancillary costs and a combined routine cost/length of stay ceiling. Once allowable costs were determined, rates for 1983 were calculated by inflating the costs by a trend factor. In 1984 and 1985, a "rate-to-rate" methodology is applied. The system provides for the establishment of bad debt and charity care pools on a regional basis to be supported by the payers.

Status: Rates have been set and the payment implemented, effective January 1, 1983. Regulations for the processing of appeals and administration of the various bad debt and charity care pools are currently being developed.

Prospective Payment System for Acute and Chronic Care Hospitals in Maryland

Project No.: 500-80-0044
Period: June 1980 - September 1983
Funding: $ 2,037,563
Contractor: Maryland Health Services Cost Review Commission
Baltimore, Md.
Project Officer: Thomas A. Noplock
Division of Hospital Experimentation

Description: This project is testing the long-term effects of an all-payer, Statewide hospital prospective payment system in Maryland. The Maryland Project uses a public utility commission's approach to hospital rate regulation. The Maryland Health Services Cost Review Commission established hospital rates and then adjusted them for such items as inflation, volume changes, and pass-through costs. Currently, Maryland employs three separate systems: a detailed budget review system for individual hospitals; an automatic annual inflation adjustment for individual hospitals without a total budget review; and a payment system based on diagnosis, the Guaranteed Inpatient Revenue system. The Maryland Health Services Cost Review Commission will continue to refine the present prospective payment system to include case mix for small hospitals, and extend its activities into additional areas of health services review and payment (e.g., ambulatory and chronic care) while trying to keep the rate of increase in hospital costs below the national average.

Status: The current Medicare and Medicaid waivers will terminate June 30, 1983; however, the Maryland Commission will seek to have the waivers continued under Section 903 of the Omnibus Reconciliation Act of 1981. A final report is expected by October 1983. The present Medicare and Medicaid demonstration waivers have been

extended under the authority of Section 402 of the Social Security Amendments of 1967 until the regulations are promulgated from section 1886(c) and the State's system has been considered under this new Medicare program waiver authority.

Case Mix

An Examination of the Case-Mix Length of Stay, Costs, and Reimbursement of Rural Hospitals

Project No.: 18-P-97703/702
Period: September 1980 - September 1982
Funding: $ 184,318
Grantee: University of Iowa
Graduate Program in Hospital and Health
Iowa City, Iowa
Project Officer: John T. Petrie
Division of Reimbursement Studies

Description: This research examines the performance of rural hospitals with an interest in determining the influence of case-mix, patient referral patterns, and Medicare utilization on the costs, length of stays, and reimbursement in hospitals. The study examines discharge data using AUTOGRP case-mix methodology.

Status: The final report is expected in December 1983. Preliminary results indicate that rural hospitals transfer many of their more complex cases to urban hospitals.

Measuring the Cost of Case Mix Using Patient Management Algorithms

Project No.: 18-P-97063/3-05
Period: September 1978 - July 1984
Funding: $ 1,166,846
Grantee: Blue Cross of Western Pennsylvania
Pittsburgh, Pa.
Project Officer: Ken Haber
Division of Reimbursement Studies

Description: This project will develop and test a case-type classification system for output measurement and hospital classification using clinical management criteria and category weights based on cost. This research is developing relative weights for the categories based on the services that clinicians believe typical patients should receive. It is also developing the capability to calculate alternative weights based on the services that the average patient actually receives as indicated by billed charges.

Status: The patient management categories (PMC's), the related computer decision rules, and the physician consensus of the PMC's will be completed by July 1984. A request to extend the project period to that date is being processed. Proximate patient management categories (which can be applied with current discharge abstract data), a comparison of the diagnosis-related groups and the PMC methods, and a method for adjusting cost weights for comorbid cases have already been completed. Current objectives include computerizing the comorbidity adjustment to the cost weights, analyzing deaths and related cost-weight adjustment methods, and analyzing case-mix changes for hospitals over time.

Capital

Medicare-Medicaid Payment Policies and Capital Formation

Project No.: 18-P-98267/1-01
Period: April 1983 - September 1984
Funding: $ 274,805
Grantee: Center for Health Economics Research
Chestnut Hill, Mass.
Project Officer: Philip Cotterill
Division of Economic Analysis

Description: The objective of this project is to provide policymakers with new information on the effects of Medicare and Medicaid payment policies on hospital capital formation, past and future. First, there is a need to analyze the combined, overall effect of Medicare and Medicaid payment policies so that a policy can be designed that results in adequate, but not excessive, hospital investment in plant and equipment. Second, the project would analyze the impact of payment policies on hospital decisions to implement cost-saving or cost-inducing technologies. To complement these analyses, the following issues would be studied empirically:

- The effect of hospital dependence on Medicare and Medicaid revenues on hospital financial status and capital formation.
- The effects of alternative payment policies, especially prospective payment, on capital formation.
- The relationships between Medicare and Medicaid payment policies, hospital competition, and capital formation.
- The effects of public payment policies on hospital closures and mergers.
- The adoption of cost-saving or cost-inducing technology.

Data to be used in the project includes the Abt National Rate-Setting Medicare Cost Report file of 2,500 hospitals covering the period 1970-79. Parallel analyses will be conducted using American Hospital Association data for the period 1974-82. These files are operational currently. Some additional data will be collected for small pilot studies.

Status: Progress in the first 3 months of the project has involved preparation of data files and refinement of research design.

Analysis of Interest Income on Funded Depreciation

Funding: Intramural
Project Director: J. Michael Fitzmaurice
Division of Reimbursement Studies

Description: This study examines a potential policy proposal which would direct the Medicare program to offset reimbursed interest expense of hospitals by the amount of interest income earned on funded depreciation. A sample of 1979 hospital Medicare cost reports were abstracted to analyze direct depreciation, interest expense, funded depreciation, and fixed assets. Special focus was placed on: the quality of the data reported; the potential overall savings to the Medicare program if a policy were implemented to reduce reimbursement of interest expense allowed under Medicare by the amount of interest income earned by the hospital on funded depreciation; the distribution of these savings by several hospital characteristics; and the variation in the estimated life of hospital capital by type of asset, hospital characteristic, and region of the country.

Status: This study uncovers and documents substantial problems with the quantity and quality of hospital reporting. This analysis suggests a finding that, if interest income from funded depreciation were to be subtracted from interest expense before Medicare reimbursement of interest expense, nonprofit hospitals would be more heavily affected by this policy than other hospitals. The report emphasizes that the sample itself is not representative of the hosptial population and, therefore, should not be used to generate estimated savings for the U.S. hospital population.

Data Development and Analyses

Automated Hospital Information Systems: Development of Evaluation Methods

Project No.: 18-P-97925/9-02
Period: January 1981 - September 1984
Funding: $ 464,657
Grantee: Lutheran Hospital Society of Southern California
Los Angeles, Calif.
Project Officer: William Damrosch
Division of Hospital Experimentation

Description: This 4-year project examines the ramifications of using various types of automated hospital information systems within the hospital. The sponsor is developing a methodology for establishing a cost-benefit analysis for the types of systems to be installed in various hospital settings. A manual will be developed to enable hospitals to make their own informed judgements about the installation of an automated hospital information system.

Status: Several refinements are being considered and a computerized evaluation package is being prepared. As a result of field tests and in response to requests from the industry, Lutheran has broadened the scope of its manual to enhance its utility.

Data for Hospital Cost Monitoring and Analysis of Hospital Costs

Project No.: 500-80-0066
Period: September 1980 - December 1984
Funding: $ 931,800
Contractor: American Hospital Association
Chicago, Ill.
Project Officer: J. Michael Fitzmaurice
Division of Reimbursement Studies

Description: This project obtains survey data from a set of hospitals that are surveyed monthly about their costs and activities. This serves as a prime source of outside data on the performance of hospitals and is used in Health Care Financing Administration (HCFA) analyses, research, and publications.

Status: To date, HCFA has received monthly "National Hospital Panel Survey Reports" and monthly "Community Hospital Statistics" through March 1983. The data are available in both hard copy and computer tape format.

Statistical and Analytical Services to Support Provider Reimbursement Studies

Project No.: 500-78-0041
Period: September 1978 - December 1983
Funding: $ 1,555,000
Contractor: Applied Management Sciences
Silver Spring, Md.
Project Officer: J. Michael Fitzmaurice
Division of Reimbursement Studies

Description: This is a project to provide statistical and analytical support for studies of hospital cost variation and hospital cost inflation. This includes simulations of models developed and directed by the Office of Research as well as a number of separate investigations, such as analysis of the influence of various payment systems on hospital cost behavior. With the support of the contractor, this project has been able to supplement existing Medicare hospital data bases with information targeted to specific program administration and policy research questions and to respond rapidly to the need for such research when necessary.

Status: In the past fiscal year, four final reports have been delivered to the Health Care Financing Administration. These reports have been jointly produced by the contractor and the Office of Research. The reports are:

- "Analysis of Interest Income on Funded Depreciation (November 30, 1982)."
- "Analysis of a Proposed Title XVIII Offset of Hospital Part B Losses with Surpluses Generated under Part A (April 6, 1983)."
- "Analysis of Hospital Cost Centers (June 10, 1983)."
- "Analysis of the Ratio of Outpatient Costs to Charges (April 19, 1983)."

Financially Troubled Hospitals

Bedford-Stuyvesant/Crown Heights Demonstration Project

Project No: 95-P-97605/2-04
Period: November 1979 - May 1983
Grantee: New York State Department of Social Services
Albany, N.Y.
Project Officer: Rose M. Truax
Division of Hospital Experimentation

Description: The goal of the project was to achieve fundamental changes in the health care delivery system in the project catchment area. This 4-year demonstration project tests new reimbursement strategies formulated to provide for Federal coverage of a proportionate share of uncompensated care costs. The project tests whether financial stability promotes a reconfiguration of the delivery system and subsequent viability.

Status: System changes as part of the project were:

- Consolidation of the nonemergency ambulatory care currently provided by the hospitals under a separate corporation. (Certificate-of-Need application submitted October 1981.)

- Consolidation at Jewish Hospital and Medical Center of Brooklyn (JHMCB) of the obstetrical services currently provided by this hospital and St. John's. (Application submitted September 1981.)

- Full merger of JHMCB and St. John's with a combined reduction in beds of 245, from 945 to 700. (Application submitted May 1982 - beds since reduced to 650 complement.)

The merger application was approved by the New York State Public Health Council on November 19, 1982, thus completing the State approval process. A 6-month extension of the project was granted for November 26, 1982 through May 27, 1983 to facilitate the transition to standard payment methods. A final report is due Fall 1983.

Metropolitan Comprehensive Care Program: A Health Systems Organization Demonstration

Project No.: 11-P-97805/2-03
Period: September 1980 - September 1986
Grantee: New York State Department of Social Services
Albany, N.Y.
Project Officer: Rose M. Truax
Division of Hospital Experimentation

Description: The demonstration is designed to test a new financing and health care role for municipal hospitals. The demonstration is specifically targeted for the medically indigent and all other members of the East Harlem community. A 5-year study which is based at Metropolitan Hospital will provide coverage to a maximum of 17,100 poor and near-poor residents of the community who are ineligible for Medicaid coverage under existing Federal/State regulations. The five critical components of the demonstration are:

- o The case management system.
- o The reorganization of the hospital management and financial systems.
- o The introduction of the Citycaid program.
- o Improved screening for Medicaid, Citycaid, and other third-party insurance.
- o The establishment of a State qualified health maintenance organization (HMO).

Status: The focus of the first and second year activities was establishing administrative mechanisms and implementing organizational changes to support a case-management approach to medical care for an enrolled population. The third year has focused on planning for the HMO. Enrollment levels have been growing. As of February 1983, the program had enrolled 4,675 in Citycaid, 3,505 Medicaid recipients, and 7,431 others.

Alternative Methodologies for Reimbursement and Delivery of Health Care Services to Inner City Poor

Project No.:	11-P-97863/1-03
Period:	January 1981 - January 1984
Grantee:	Massachusetts Department of Public Welfare Boston, Mass.
Project Officer:	Rose M. Truax Division of Hospital Experimentation

Description: This 3-year demonstration project, the Boston Health Plan, tests the effectiveness of a case-management system in a network of Community Health Centers

linked to an inner city hospital. Reimbursement is a prospective capitation method. The approach will demonstrate that:

- Financial viability can be achieved by the use of new "strategies" in the provision of patient care and methods of reimbursement.
- The hospital can serve as an effective case manager, reducing costs and improving health outcomes.

Status: The project became operational November 1, 1981, and six primary care centers were providing services by February 1983. As of July 1, 1983, the centers had enrolled 9,440 newly eligibles, 1,253 city employees, and 695 currently eligible Medicaid recipients. This is the third and last year of this project; the focus for the year is the future of Boston Health Plan after the grant period.

Strategies to Improve the Financial Viability of the Urban Hospital

Project No.: 11-P-97866/4-03
Period: January 1981 - September 1984
Grantee: Florida Department of Health and Rehabilitative Services
Tallahassee, Fla.
Project Officer: Rose M. Truax
Division of Hospital Experimentation

Description: This 4-year demonstration project will test the feasibility of covering a medically needy population in Florida in a capitated primary care system. Enrollees will lock themselves into care at an urban hospital and its primary care center. The services provided are limited to inpatient, outpatient, physician services, and pharmacy. The approach will demonstrate that:

- Financial viability can be achieved by the use of new "strategies" in the provision of patient care and methods of reimbursement.
- The hospital can serve as an effective case manager, reducing costs and improving health outcomes.

Status: The project became operational October 1, 1981, with the opening of a new primary care center at the University Hospital of Jacksonville. As of July 1, 1983, there were 15,988 enrollees at the center--6,000 newly eligibles, 4,048 currently eligible Medicaid recipients, 1,440 Medicare recipients, 1,460 partial pay (self pay), and 3,040 charity care.

A Proposal to Relieve Financial Distress at a Congested Urban Medical Center

Project No.: 11-P-97817/9-03
Period: January 1981 - January 1985
Grantee: California Department of Health Services
Sacramento, Calif.
Project Officer: Rose M. Truax
Division of Hospital Experimentation

Description: This 4-year demonstration project tests the cost effectiveness of a county health maintenance system with capitated reimbursement for the medically indigent population served at the Los Angeles County/University of Southern California Medical Center and a community health care center. The approach will demonstrate that:

- Financial viability can be achieved by the use of new "strategies" in the provision of patient care and methods of reimbursement.

- The hospital can serve as an effective case manager, reducing costs and improving health outcomes.

Status: The first 2 years of this project has been a developmental phase. The project became operational February 1, 1983. There were 239 enrollees in the project as of July 1, 1983.

Other Hospital

Allocation of Resources Under the Budget Constraints Imposed by the British National Health Service

Project No.: 18-P-97647/3-02
Period: March 1980 - September 1983
Funding: $ 127,794
Grantee: The Brookings Institute
Washington, D.C.
Project Officer: J. Michael Fitzmaurice
Division of Reimbursement Studies

Description: The Brookings grant examines the way investment decisions are made when the British National Health Service limits expenditures for medical care. It will determine what fraction of the demand for several specific technologies was satisfied and why. The investigators visited Britain to gather epidemiological and expenditure data and information on the decisionmaking process of resource allocation.

Status: In the first year, the investigators added a survey of American and British physicians to the project and increased the planned length of their final report. It is expected that a full-length book will result from this project. It will show how restricting health expenditures in a particular area leads to substitutions of other and possibly less costly medical care treatments.

Data Development and Analyses

Analysis of Survey Data and Physician Practice Costs and Income: Physician Earnings and Return to Medical Training and Specialization

Project No.: 500-78-0054
Period: September 1978 - February 1983
Funding: $ 124,162
Contractor: Institute for Demographics and Economic Studies, Inc.
New Haven, Conn.
Project Officer: James Cantwell
Division of Reimbursement Studies

Description: The purpose of this project is to compute rates of return to medical education by specialty, comparing them with other occupations and assessing the impact on rates of return to various increases in medical education costs.

Status: A final report was received in March 1983. Relative to other professionals, returns to medical education were substantial. In addition, between 1972 and 1977 the earnings of young incumbents in professional, technical, and managerial occupations declined, often substantially. The significant exceptions to this trend were physicians and other health professionals. Returns by specialty indicate that opthalmology, cardiology, and surgery were especially high-return specialties.

Alternative Methods for Describing Physicians' Services Performed and Billed

Project No.: 500-81-0054
Period: September 1981 - November 1983
Funding: $ 338,120
Contractor: Health Economics Research, Inc.
Chestnut Hill, Mass.
Project Officer: James Cantwell
Division of Reimbursement Studies

Description: This study analyzes the advantages and disadvantages of many different methods of combining or packaging physician services for reporting and billing purposes. This includes analysis of the extent to which current Medicare billing procedures may foster unpackaging. The project has developed and tested new ways of packaging physician services for reimbursement purposes, particularly the feasibility of using medical criteria such as diagnosis and reason-for-visit. National Ambulatory Medical Care data for 1979 and 1980 and Medicare Part B data from Michigan and South Carolina have been used in the project.

Status: The final report is due November 1983, and it will address alternative approaches to packaging and their medical reasonableness, variation in physician charges and inputs across packages, and inefficiencies and inequities introduced by packaging. Types of packages include collapsed procedure packages, office visit packages, special procedure packages, and condition packages.

Analysis of Physician Pricing Behavior, Third-Party Administrative Practices

Project No.: 600-76-0058
Period: April 1976 - September 1983
Funding: $ 741,570
Contractor: Harvard University
Cambridge, Mass.
Project Officer: William Sobaski
Division of Reimbursement Studies

Description: This study deals with physician response to reimbursement alternatives, including analysis of price trends, relative values, and relations between medicine and private health insurance.

Status: All interim reports completed. Final report is expected in late 1983.

- The study of price trends showed that wide disparities both within and across areas may be concealed by national price trend figures.
- A unique methodological approach to relative value studies was undertaken that showed large imbalances exist between payments for technological procedures versus primary care.
- The nonprofit and for-profit private insurance sectors were shown to employ quite different strategies in establishing relationships with medicine, albeit both cover positive relationships.
- A new model of supply-and-demand factor interactions in the medical market is being developed.

Aspects of Physician Behavior in Medicare and Medicaid

Project No.: 95-P-97178
Period: September 1978 - December 1983
Funding: $ 730,313
Grantee: The Urban Institute
Washington, D.C.
Project Officer: James Cantwell
Division of Reimbursement Studies

Description: This project examines three areas of physician reimbursement:

- Provision of pathology services.
- The effect of reimbursement on physician practice location.
- Simulation and analysis of alternative reimbursement systems.

Status: Work analyzing the effects of reimbursement on physician practice location, the Medicare Economic Index, and Medicare-Medicaid fee levels and differences have been completed. During the fifth year, two ongoing tasks will be completed and eight additional tasks involving simulations and behavioral modeling will be undertaken, using existing data files.

Alternative Methods for Developing a Relative Value Scale of Physician Fees

Project No.: 500-81-0053
Period: September 1981 - March 1984
Funding: $ 287,557
Contractor: The Urban Institute
Washington, D.C.
Project Officer: James Cantwell
Division of Reimbursement Studies

Description: This project explores criteria and methods underlying relative value scales for physician services. Some of these methods will be applied to approximately 100 procedures to develop relative value scales. The study will address the implications of adopting different construction methods.

Status: Five broad classes of approaches to developing relative value scales are discussed in the first year report, received in February 1983. These five classes of methods are charge-based, statistical cost function, time-based, micro costing, and group decisionmaking approaches.

Costs, Outcomes, and Competiton in the End-Stage Renal Disease Program

Project No.: 18-P-98056/3
Period: August 1981 - August 1983
Funding: $ 407,096
Grantee: The Urban Institute
Washington, D.C.
Project Officer: James Cantwell
Division of Reimbursement Studies

Description: This project will aid in the overall assessment of the End-Stage Renal Disease (ESRD) program by studying three aspects:

- The determinants of the total cost of the program.
- Some measures of the health outcomes produced by the program.
- Alternative ways of organizing and improving the services.

Particular attention will be given to the effects of competition on the cost and quality of care among facilities in an area.

Status: Two major papers have been produced thus far under this grant: "Pro Competitive Health Insurance Proposals and their Implications for the ESRD Program" and "Competition and Efficiency in the ESRD Program." The first paper concludes that there are numerous ways to induce more competitive behavior in the delivery of ESRD service, especially maintenance dialysis, although there are significant implementation problems with some strategies. The second paper concludes that analysis of cost alone cannot determine appropriate reimbursement levels, because that determination requires a prior political decision of the appropriate level of amenities.

Pricing Behavior of Pennsylvania Physicians Since 1970

Project No.: 500-80-0011
Period: January 1980 - February 1983
Funding: $ 49,271
Contractor: Pennsylvania Blue Shield
Camp Hill, Pa.
Project Officer: James Cantwell
Division of Reimbursement Studies

Description: This project funds the collection of data to study longitudinal changes in physician service pricing levels in Pennsylvania and their association with changes in practice and sociodemographic characteristics since 1970. The analysis of the data is funded under a separate contract (600-76-0146).

Status: This project was completed in February 1983. The project found substantial variation in fees charged by Pennsylvania physicians. There was clear evidence of differences in price between Medicare and Blue Shield programs. The simulation portions of the study found that Medicare aggregate program cost varied very little with changes in physician specialty or locality designations.

Survey of Physicians' Practice Costs and Incomes: Redesign and Implementation

Project No.: 500-83-0025
Period: June 1983 - June 1985
Funding: $ 1,508,942
Contractor: National Opinion Research Center
Chicago, Ill.
Project Officer: James Cantwell
Division of Reimbursement Studies

Description: This project will assess the design of the survey instruments, the design of the sample, and the data collection methodology of the 1976, 1977, and 1978 Health Care Financing Administration surveys of physicians' practice costs and incomes. A new instrument will be designed, a pretest will be conducted, and then approximately 5,000 physicians will be surveyed in 1984. An important use of the data will be to refine the Medicare Economic Index.

Status: This project was initiated June 24, 1983.

Assignment Rates Revisited

Funding: Intramural
Project Director: Alma McMillan
Division of Beneficiary Studies

Description: The level of the assignment rate for physicians' services is of continuing interest. Beneficiaries are affected financially when the physician elects not to accept payment for services on an assigned basis. Data on physician assignment rates through 1978 have been published earlier. This study examines recent trends through 1981 in assignment rates by age, sex, race, and State. Assignment rates by physician specialty are also analyzed.

Status: Preliminary data show that in 1980 about 49 percent of services to aged Medicare beneficiaries and 66 percent of services to disabled beneficiaries were assigned. A working paper on this subject will be produced in Fall 1983.

Prospective Payment of Physicians

Funding: Intramural
Project Director: James Cantwell
Division of Reimbursement Studies

Description: Section 603 of Public Law 98-21, the Social Security Amendments of 1983, requires the Secretary, Department of Health and Human Services, during Fiscal Year 1984, to begin the collection of data necessary to compute, by diagnosis-related groups (DRG's), the amount of physician charges for services furnished to hospital inpatients classified in those DRG's. A report to Congress due in 1985 must include recommendations on the advisability and feasibility of determining payment for inpatient physicians' services on a DRG-type classification.

Status: Intramural work has begun to examine the level and stability of outlays for physician services by DRG's in Medicare claims data samples. This initial work will emphasize regional, specialty, and type of service patterns for high frequency DRG's. As larger data sets become available, analyses will expand to the remaining DRG's. Data file construction and specification of data display tables to be produced began in June 1983.

Other Physician Payment

Physician Reimbursement and Continuing Care under Medicaid Suffolk County, New York

Project No.: 11-P-98052/2-02
Period: September 1981 - December 1985
Funding: $ 618,593
Grantee: Department of Social Services
Albany, N.Y.
Project Officer: Sherrie Fried
Division of Health Systems and Special Studies

Description: This demonstration is designed to test the impact of alternative methods of physician reimbursement on the provision of continuing care for Medicaid children in Suffolk County, N. Y. The methods include the current fee schedule, a fee-for-service/continuing care method that reimburses physicians at a higher rate for accepting continuing comprehensive care, and a comprehensive prepayment plan.

Status: The project began the operational phase in July 1983. Major milestones include approval by the Health Care Financing Administration of the continuation request; development of capitation rates and an augmented fee schedule; development of claim payment, data collection, and management reporting systems; and enrollment of physicians and recipients.

Studies in Physician Reimbursement

Project No.: 95-P-97309/2
Period: June 1979 - December 1982
Funding: $ 330,802
Grantee: Princeton University
Princeton, N.J.
Project Officer: James Cantwell
Division of Reimbursement Studies

Description: This study examined the role of fee schedules in physician reimbursment under third-party payment systems in Europe and Canada. Specific tasks included development of the conceptual basis for fee schedules and analytic frameworks for assessment of changes within them, as well as descriptive analyses of fee schedules and relative price structures in the United States.

Status: Several country-specific papers have been produced on physician fee determination systems. The paper on the French system was written by Simone Sandier of CREDOC, the French health economics research institute. The paper on the German physician fee system was written by the late Ulrich Geissler, and an excerpt from that paper will be published in the Spring 1984 issue of the Health Care Financing Review. Uwe Reinhardt's paper on the German health funds and negotiations under their system was published in the December 1981 issue of the Health Care Financing Review. Both the German and French systems have shown that uniform relative value schedules are possible; in fact, the French in effect have a nationwide fee schedule. The Germans have been trying to alter their relative value schedules to improve the relative position of primary care services, but as yet without much success. A draft final report has been received. It addresses theoretical perspectives on physician compensation in the United States, Canada, France, West Germany, and Italy.

Impact of Physician Supply and Regulation on Physician Fees and Utilization of Services

Project No.: 18-P-97619/5
Period: March 1980 - March 1983
Funding: $ 408,287
Grantee: Blue Cross/Blue Shield of Michigan
Detroit, Mich.
Project Officer: Benson Dutton
Division of Reimbursement Studies

Description: Blue Cross and Blue Shield of Michigan (BCBSM) has used paid claims files to examine the issue of physician-induced demand. BCBSM has also examined market areas in Michigan with private and Medicare paid claims from 1975 to 1980. In addition, the study is investigating the impact of physician supply and regulation on the price and quantity of physician services. To supplement the paid claims data, BCBSM has surveyed a sample of Michigan physicians to determine amenities, workload/hours, non-Blue Shield volume and charges. This project will describe and analyze variation in per capita use across market areas. BCBSM is using patient illness diagnostic tracers from physician billing data. The inducement hypothesis is to be tested using a "Reinhardt test" of physicians' fees while holding relevant supply, demand, and amenities variables constant.

Status: The study identified 15 market areas in Michigan and showed that there were major differences between market areas in use rates as well as the growth in those rates. The areas with the highest use rates in 1975 were also the markets with the highest growth in use. On induced demand, the data support the hypothesis that an increase in the availability of doctors increases the use of services, but the evidence refutes the target income hypothesis by showing that fees move toward competitive levels. BCBSM interim reports were very useful in resolving the clinic locality issue in Michigan raised by Congressman Robert Davis (R-MI) in 1982. Other reports received include:

- "Medicare Assignment Rates in Michigan"
- "The Effects of Physician Availability on Fees and the Demand for Doctors' Services"
- "Survey of Michigan Physicians' Practice Characteristics"
- "Medicare Fees, Use, and Assignment Rates in Michigan's Physician Service Markets"
- "Fees or Use? What's Responsible for Rising Health Care Costs?"
- "The Determination of Medicare Market Areas and Medicare Fees, and Use in Michigan"

Skilled Nursing Facility Prospective Payment

Alternative Nursing Home Reimbursement Systems for Medicare

Project No.: 18-P-98274/3-01
Period: January 1983 - December 1983
Funding: $ 155,605
Grantee: The Urban Institute
Washington, D.C.
Project Officer: Philip Cotterill
Division of Economic Analysis

Description: This study will simulate alternative approaches to prospective payment for Medicare skilled nursing facilities (SNF's) and investigate administrative factors that affect the efficiency of patient-related rate payment systems. The study utilized Medicare SNF cost reports and Medicaid cost reports for 3,500 nursing homes in 10 States for the period 1978-80. The 10 States included in the study are: California, Connecticut, Georgia, Illinois, Maryland, Massachusetts, Minnesota, New York, Washington, and West Virginia.

Status: Analysis of the Medicare cost reports of skilled nursing facilities (SNF's) has shown that several proxy measures of case mix are important factors in explaining differences in SNF per diem costs. Higher costs are associated with a greater percentage of Medicare days, a higher number of admissions per bed, and greater nursing hours per inpatient day. These factors may indicate facilities with a greater orientation towards the short-term, rehabilitative Medicare patient. They only partially explain the higher costs observed, for hospital-based, as opposed to freestanding, SNF's.

New York State Capitation Payment System for Long-Term Care

Project No.: 95-P-98194/2-02
Period: March 1982 - June 1986
Funding: $ 659,632
Grantee: New York State Department of Social Services
Albany, N.Y.
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Description: The purpose of this demonstration is to reduce the backup of hospitalized Medicaid patients who cannot be discharged because of the limited availability of nursing home beds. In an effort to constrain the escalation of hospital expenditures, the Rochester Area Hospitals' Corporation has proposed a risk-sharing capitation method of reimbursement which provides positive incentives for appropriate placement.

Status: The first year of this project was characterized by intensive negotiations between the New York State Department of Social Services and the Rochester Area Hospitals' Corporation. Discussion focused on the design and implementaion of the

demonstration. The operational segment of the demonstration is scheduled to begin September 15, 1983.

West Virginia Long-Term Care, Quality-Cost Control System

Project No.: 11-P-97149/4-03
Period: April 1980 - December 1983
Grantee: State of West Virginia, Department of Welfare
Charlestown, West Va.
Project Officer: Tom Kickham
Division of Long-Term Care Experimentation

Description: This project is designed to implement and evaluate a Medicaid long-term care prospective reimbursement system based on reimbursement for services needed by and provided to patients at a reasonable cost. The reimbursement system utilizes three components on which to set the facility rate: nursing services, operating costs, and capital investment.

Status: This project is currently in its third and final year. The tasks completed in the first 2 years included the design and implementation of uniform accounting and reporting procedures, definition of the Model Facility Standards, initial appraisals of all facilities, the evaluation of the appraisals, and the establishment of a rate of return.

Longitudinal Study of the Impact of Prospective Reimbursement Under Medicaid on Nursing Home Care in Maine

Project No.: 18-P-98307/1-01
Period: June 1983 - June 1986
Funding: $ 467,314
Grantee: University of Southern Maine
Portland, Maine
Project Officer: Philip Cotterill
Division of Economic Analysis

Description: This project studies the recently implemented nursing home prospective reimbursement system in Maine. The study will provide a longitudinal evaluation of the design and implementation of the system for intermediate care facilities in the State and of the system's effectiveness in achieving the policy goals of containing costs, maintaining or improving quality, and ensuring access to nursing home care by Medicaid recipients. The study consists of three major components:

- An impact analysis of the effects of prospective reimburement on costs, quality, and access.
- A case study of the politics of the implementation of prospective reimbursement.
- An analysis of organizational and management response of nursing home administrators to the changes resulting from prospective reimbursement. The hypotheses of the study are closely tied to the objectives of recently passed reimbursement legislation which includes incentives for maintaining

and increasing Medicaid patient load. The grantee will also try to measure immediate versus long-term effects of the new system on costs to the State.

Status: This project was initiated June 1, 1983.

Channeling

Evaluation of Coordinated Community Oriented Long-Term Care Demonstration

Project No.: 500-80-0073
Period: September 1980 - December 1983
Funding: $ 1,999,980
Contractor: Berkeley Planning Associates
Berkeley, Calif.
Project Officer: Spike Duzor
Evaluative Studies Staff

Description: This long-term care project evaluates a series of demonstration projects on the delivery of coordinated community care services. The demonstrations test whether care tailored to a client's needs can preclude moving them out of the community or into expensive institutional care settings.

Status: The contractor has completed draft case studies for the participating projects. These case studies highlight the history and origin of the project, describe project organization, and operation issues. A final report is expected in December 1983 and will focus on quality of care and cost-effectiveness issues.

National Long-Term Care Channeling Demonstrations

Period: September 1980 - May 1985

Description: This is a major national research and demonstration program. It is a combined effort of three components in the Department of Health and Human Services: the Health Care Financing Administration (HCFA); the Office of the Assistant Secretary for Planning and Evaluation, Office of the Secretary; and the Administration on Aging, Office of Human Development Services. The program is testing whether and to what extent the long-term care needs of elderly impaired persons can be met in a cost-effective way through a community-based system of comprehensive needs assessment, care planning, and case management. These components are the core channeling services. Five of the projects were designated as "complex model projects." These projects alter the basic channeling model by adding three program elements under HCFA waivers: expanded Medicare and Medicaid service coverage, authorization to approve reimbursement for services, and limitations on per capita expenditures.

Project Nos.: 11-P-98211/4-01
HHS-100-80-0136
Funding: $ 932,896
Contractor/ Grantee: Florida Department of Health and Rehabilitative Services
Tallahassee, Fla.
Project Officer: William Saunders
Division of Long-Term Care Experimentation

Status: The Miami Jewish Home and Hospital for the Aged has been designated as the organization responsible for implementing the Florida project. This site has been selected as a complex model project. The project catchment area includes the City of Miami and several surrounding communities. The project began serving clients in May 1982. Currently, this site has more than 395 clients. The organization expected to reach a caseload of 450 clients by the end of July 1983.

Project No.: HHS-100-80-0138
Funding: $ 700,000
Contractor: Kentucky Cabinet for Human Resources
Frankfort, Ky.
Project Officer: William Saunders
Division of Long-Term Care Experimentation

Status: The Kentucky Department for Social Services has been designated as the agency responsible for implementing the Kentucky project. This site has been selected as a basic model project. The project catchment area covers eight rural counties in eastern Kentucky. The project began serving clients in February 1982. Currently, this site has 200 clients. The department expected to reach a caseload of 240 clients by the end of July 1983.

Project No.: HHS-100-80-0139
Funding: $ 609,839
Contractor: Maine Department of Human Services
Augusta, Maine
Project Officer: Leslie Saber
Division of Long-Term Care Experimentation

Status: The Maine demonstration site is a basic model project administered under a subcontract with Southern Maine Senior Citizens, Inc., an Area Agency on Aging in Portland. The 2-county catchment area, Cumberland and York Counties, covers 2,000 square miles. The project began serving clients in February 1982. Currently, the project has more than 210 clients in the active caseload. The project expected to reach an active caseload of 225 clients by the end of July 1983.

Project Nos.: 11-P-98210/1-01
HHS-100-80-0141
Funding: $ 1,657,617
Contractor/ Grantee: Massachusetts Department of Elder Affairs
Boston, Mass.
Project Officer: Leslie Saber
Division of Long-Term Care Experimentation

Status: The Massachusetts Channeling demonstration is a complex model site operated by Greater Lynn Senior Services. The catchment area includes Greater Lynn and the Beverly area. The project began serving clients in May 1982. Currently, the project has more than 260 active clients and expected to reach an active caseload of 300 clients by the end of July 1983. The project's major referral sources are the Visiting Nurse Association, hospitals, and the Greater Lynn Senior Services.

Project No.:	11-P-98213/2-01
Grantee:	New York State Department of Social Services Albany, N.Y.
Project Officer:	Thomas M. Kickham Division of Long-Term Care Experimentation

Status: The Rennselaer County Department for the Aging has been designated as the agency responsible for implementing the New York project. This site has been selected as a complex model project. The project catchment area is Rennselaer County, New York. The project began serving clients in May 1982. Currently, the site has approximately 175 clients. The project expected to reach a caseload of 200 by the end of July 1983.

Project No.:	11-P-98209/5-01
Grantee:	Ohio Department of Public Welfare Columbus, Ohio
Project Officer:	Thomas M. Kickham Division of Long-Term Care Experimentation

Status: The Cuyahoga County Board Commissioners has been designated as the agency responsible for implementing the Ohio project. The project site is administered by the Western Reserve Area Agency on Aging. The project catchment area covers Cuyahoga County, which consists of the City of Cleveland and 59 suburbs. The project began serving clients in May 1982. Currently, the site has approximately 428 clients. The project expected to reach a caseload of 450 clients by the end of July 1983.

Project Nos.:	11-P-98212/3-01 HHS-100-80-0146
Funding:	$ 2,235,982
Contractor/ Grantee:	Pennsylvania Department of Public Welfare Harrisburg, Pa.
Project Officer:	Leslie Saber Division of Long-Term Care Experimentation

Status: The Pennsylvania Channeling project is operated through a subcontract with the Philadelphia Corporation for Aging. This site is a fully centralized complex model project site. The catchment area covers more than 129 square miles and includes the city and county of Philadelphia. The project began serving clients in May 1982. By the middle of June 1983, the project reached its target caseload of 500 clients. For the duration of the project's maintenance phase, it expects to continue serving an active caseload of 500-520 clients.

Community-Based Care

Medicare/Medicaid Hospice Demonstration

Period: October 1980 - October 1983

Description: This demonstration was designed to gather data on the cost, utilization, and quality of hospice care with major emphasis on the provision of home care services (for example, continuous nursing care and prescription drugs). There are 26 sites, and each site provides care to terminally ill Medicare beneficiaries and Medicaid recipients having a life expectancy of 6 months or less. An interdisciplinary team approach is utilized to maintain the patient at home in a comfortable, alert, and pain-free state.

Status: Because Public Law 97-248 mandated a Medicare hospice benefit and the extension of the demonstration, each site continues to enroll Medicare beneficiaries. Medicare utilization statistics for the second year reflected an increase of 43 percent over the first year and Medicaid showed a 4-percent increase. The quality of data being collected not only indicates an understanding and application of the service definitions, but an improvement in the use of project reports and forms and increased perception of the project's objectives.

Project No.:	95-P-50-109/9-02
Grantee:	Santa Barbara Visiting Nurse Association Santa Barbara, Calif.
Project Officer:	Teresa Schoen Division of Long-Term Care Experimentation

Project No.:	95-P-50022/9-02
Grantee:	San Diego Hospice Corporation San Diego, Calif.
Project Officer:	Teresa Schoen Division of Long-Term Care Experimentation

Project No.:	95-P-50194/9-02
Grantee:	Hospice of Marin San Rafael, Calif.
Project Officer:	Teresa Schoen Division of Long-Term Care Experimentation

Project No.:	95-P-50148/9-02
Grantee:	San Pedro Peninsula Hospital San Pedro, Calif.
Project Officer:	Teresa Schoen Division of Long-Term Care Experimentation

Project No.:	95-P-50149/9-02
Grantee:	Hospital Home Health Care Agency of California Torrance, Calif.
Project Officer:	Teresa Schoen Division of Long-Term Care Experimentation

Project No.:	95-P-50020/8-02
Grantee:	Boulder County Hospice, Inc. Boulder, Colo.
Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation

Project No.:	95-P-50037/1-02
Grantee:	The Connecticut Hospice, Inc. Branford, Conn.
Project Officer:	Patricia Talley Division of Long-Term Care Experimentation

Project No.:	95-P-50120/4-02
Grantee:	Hospice, Inc. Miami, Fla.
Project Officer:	Patricia Talley Division of Long-Term Care Experimentation

Project No.:	95-P-50079/4-02
Grantee:	Hospice Care, Inc. Seminole, Fla.
Project Officer:	Patricia Talley Division of Long-Term Care Experimentation

Project No.:	95-P-50083/1-02
Grantee:	Hospice of the Good Shepherd, Inc. Waban, Mass.
Project Officer:	Patricia Talley Division of Long-Term Care Experimentation

Project No.:	95-P-50085/1-02
Grantee:	University of Massachusetts Medical Center Palliative Care Service, Inc. Worcester, Mass.
Project Officer:	Patricia Talley Division of Long-Term Care Experimentation

Project No.:	95-P-50154/5-02
Grantee:	Bethesda Lutheran Medical Center St. Paul, Minn.
Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation

Project No.:	95-P-50122/7-02
Grantee:	Lutheran Medical Center St. Louis, Mo.
Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation

Project No.:	95-P-50001/2-02
Grantee:	Overlook Hospital Summit, N.J.
Project Officer:	Patricia Talley Division of Long-Term Care Experimentation

Project No.:	95-P-50135/6-02
Grantee:	Hospital Home Health Care, Inc. Albuquerque, N.Mex.
Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation

Project No.:	95-P-50006/2-02
Grantee:	Cabrini Hospice New York, N.Y.
Project Officer:	Patricia Talley Division of Long-Term Care Experimentation

Project No.:	95-P-50111/2-02
Grantee:	Genesee Region Home Care Association Rochester, N.Y
Project Officer:	Patricia Talley Division of Long-Term Care Experimentation

Project No.:	95-P-50267/0-02
Grantee:	Providence Medical Center Portland, Oreg.
Project Officer:	Teresa Schoen Division of Long-Term Care Experimentation

Project No.:	95-50068/6-02
Grantee:	The Visiting Nurse Association of Dallas Dallas, Tex.
Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation

Project No.:	95-P-50147/6-02
Grantee:	St. Benedict Hospital and Nursing Home San Antonio, Tex.
Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation

Project No.:	95-P-50040/1-02
Grantee:	Northern Vermont Respond Burlington, Vt.
Project Officer:	Patricia Talley Division of Long-Term Care Experimentation

Project No.:	95-P-50043/3-02
Grantee:	Hospice of Northern Virginia Arlington, Va.
Project Officer:	Teresa Schoen Division of Long-Term Care Experimentation

Project No.:	95-P-50182/3-02
Grantee:	Medical College of Virginia Richmond, Va.
Project Officer:	Teresa Schoen Division of Long-Term Care Experimentation

Project No.:	95-P-50104/0-02
Grantee:	Community Home Health Care Seattle, Wash.
Project Officer:	Teresa Schoen Division of Long-Term Care Experimentation

Project No.:	95-P-50121/5-02
Grantee:	Bellin Memorial Hospital Green Bay, Wis.
Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation

Project No.:	95-P-50132/5-02
Grantee:	Rogers Memorial Hospital, Inc. Oconomowoc, Wis.
Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation

State Medicaid Hospice Demonstration

Period: October 1980 - March 1983

Description: Fourteen States were granted waivers to gather data on the cost, utilization, and quality of hospice care provided to Medicaid recipients having a life expectancy of 6 months or less. Under the auspice of the State, an array of home care services (including continuous nursing care, bereavement assessment and counseling, and respite care) is being provided at several sites. Inpatient hospice care is also available at some sites.

Status: The States are currently in the wind-down phase of the project, because active patient enrollment ceased October 1, 1982. Services to surviving patients who enrolled prior to October 1 are still being provided. Medicaid utilization during the first project year was far lower than expected. During the second year, utilization nearly doubled.

Project No.:	11-P-50233/9-02
Grantee:	Department of Health Services Sacramento, Calif.
Project Officer:	Teresa Schoen Division of Long-Term Care Experimentation

Project No.:	11-P-50237/8-02
Grantee:	Colorado Department of Social Services Denver, Colo.
Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation

Project No.:	11-P-50255/1-02
Grantee:	Department of Income Maintenance Hartford, Conn.
Project Officer:	Patricia Talley Division of Long-Term Care Experimentation

Project No.:	11-P-50241/4-02
Grantee:	Department of Health and Rehabilitative Service Tallahassee, Fla.
Project Officer:	Patricia Talley Division of Long-Term Care Experimentation

Project No.: 11-P-50260/1-02
Grantee: Department of Public Welfare
Boston, Mass.
Project Officer: Patricia Talley
Division of Long-Term Care Experimentation

Project No.: 11-P-50226/5-02
Grantee: Department of Public Welfare
St. Paul, Minn.
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Project No.: 11-P-50242/2-02
Grantee: New Jersey Department of Human Services
Trenton, N.J.
Project Officer: Patricia Talley
Division of Long-Term Care Experimentation

Project No.: 11-P-50270/6-02
Grantee: New Mexico Human Services Department
Santa Fe, N. Mex.
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Project No.: 11-P-50256/2-02
Grantee: New York State Department of Social Services
Albany, N.Y.
Project Officer: Patricia Talley
Division of Long-Term Care Experimentation

Project No.: 11-P-50208/6-02
Grantee: Texas Department of Human Resources
Austin, Tex.
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Project No.: 11-P-50231/1-02
Grantee: Department of Social Welfare
Montpelier, Vt.
Project Officer: Patricia Talley
Division of Long-Term Care Experimentation

Project No.: 11-P-50238/3-02
Grantee: Virginia Department of Health
Richmond, Va.
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Project No.: 11-P-50229/0-02
Grantee: Department of Social and Health Services
Division of Medical Assistance, LK-11
Olympia, Wash.
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Project No.: 11-P-50264/5-02
Grantee: Department of Health and Social Services
Madison, Wis.
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

National Hospice Study

Project No.: 99-P-97793/1-03
Period: September 1980 - September 1983
Funding: $ 2,890,840
Grantee: Brown University
Providence, R.I.
Project Officer: Spike Duzor
Evaluative Studies Staff

Description: This study will evaluate the effects of providing hospice services to terminally ill Medicare and Medicaid patients. It will determine whether hospice care can provide the necessary emotional, psychological, and medical support to the terminally ill which would permit them to remain at home during their final months of illness and eliminate long and costly periods of institutionalization.

Status: Analytical files are being constructed for the final analysis. These files will link individual patient service utilization and cost information with detailed patient health status profiles and interviews. A preliminary report is expected in October 1983 and a more comprehensive final report is expected in February 1984.

Deinstitutionalization of the Chronically Mentally Ill

Project Officer: Jean L. Bainter
Division of Long-Term Care Experimentation

Description: This project is a joint effort between the Departments of Housing and Urban Development (HUD) and Health and Human Services under the Demonstration for Deinstitutionalization of the Chronically Mentally Ill. HUD is providing loans for the construction of community-based housing under section 202, and rental assistance under section 8. The Health Care Financing Administration is providing Medicaid waivers to permit reimbursement for a 3-year period for services such as case management, life skills training, supervision, and transportation.

Status: To date, 12 States have submitted section 1115 waiver-only applications and received approval. There are now 42 sites in operation serving approximately 415 residents. Additional sites are in operation in States not seeking waivers. Several levels of evaluation have been carried out resulting in section 202 standards and criteria for small, scattered site housing. The standards include service requirements for this population that must be monitored by the State Mental Health Authority. To date, there are no findings relating to the cost-effectiveness of the demonstration.

A Model Addressing the Residential Needs of the Chronically Mentally Ill

Project No.: 11-P-98117/6-01
Period: July 1982 - July 1985
Grantee: Arkansas Department of Human Services
Little Rock, Ark.

Effective and Efficient Community Support Services for the Chronically Mentally Ill

Project No.: 11-P-98000/3-02
Period: September 1981 - September 1984
Grantee: Office of Health Care Financing
Washington, D.C.

Cost-Effective Community Alternatives to Institutionalization of the Chronically Mentally Ill

Project No.: 11-P-97575/4-02
Period: April 1981 - March 1984
Grantee: Georgia Department of Medical Assistance
Atlanta, Ga.

Cost-Effective Comprehensive Community Residential Treatment of the Chronically Mentally Ill

Project No.: 11-P-98242/1-01
Period: November 1982 - November 1985
Grantee: Maine Department of Human Services
Augusta, Maine

Housing and Urban Development Demonstration Program for the Chronically Mentally Ill

Project No.: 11-P-97563/5-03
Period: May 1980 - April 1983
Grantee: Minnesota Department of Public Welfare
St. Paul, Minn.

Cost Effective Community Alternatives to Deinstitutionalization of the Chronically Mentally Ill

Project No.: 11-P-98100/1-01
Period: November 1982 - November 1985
Grantee: New Hampshire Division of Welfare
Concord, N.H.

Services in HUD Transitional Housing for Chronically Mentally Ill

Project No.: 11-P-97799/2-01
Period: August 1982 - July 1985
Grantee: New Jersey Department of Human Services
Trenton, N.J.

Deinstitutionalization of the Chronically Mentally Disabled, Cost-Effective Community Alternatives

Project No.: 11-P-98118/1-01
Period: June 1982 - June 1985
Grantee: Department of Social and Rehabilitative Services
Cranston, R.I.

Housing and Urban Development Demonstration Program for the Chronically Mentally Ill

Project No.: 11-P-97952/4-02
Period: May 1981 - May 1984
Grantee: Tennessee Department of Public Health
Nashville, Tenn.

Community Alternatives to the Institutionalization of the Chronically Mentally Ill

Project No.: 11-P-98259/1-01
Period: March 1983 - March 1986
Grantee: Connecticut Department of Income Maintenance
Hartford, Conn.

Cost-Effective Community Residential Treatment for the Mentally Ill

Project No.: 11-P-97787/1-02
Period: August 1981 - July 1984
Grantee: Vermont Agency of Human Services
Waterbury, Vt.

Highline Independent Apartment Living Project

Project No.: 11-P-98200/0-01
Period: April 1982 - April 1985
Grantee: Washington Division of Medical Assistance
Olympia, Wash.

On Lok Community Care Organization for Dependent Adults

Project No.: 95-P-97239/9-04
Period: February 1979 - July 1983
Grantee: On Lok Senior Health Services
San Francisco, Calif.
Project Officer: Jean L. Bainter
Division of Long-Term Care Experimentation

Description: This is a community-based demonstration providing long-term health and health-related services in a health maintenance organization mode. Services are provided to those functionally disabled elderly in the Chinatown-North Beach area of San Francisco that meet the State's eligibility criteria for 24-hour institutional care and who are entitled to Medicare. Medicare waivers were granted to provide reimbursement for a comprehensive package of services and to build a data base for the development of a capitation system of reimbursement.

Status: The On Lok demonstration has been extended through October 31, 1983 to provide sufficient time to initiate a 3-year, at-risk, capitated payment demonstration (Medicare and Medicaid) that was mandated by Congress in the Social Security Amendments of 1983. The current demonstration is being evaluated by the Health Care Financing Administration in its cross-cutting long-term care study. On Lok's final report is in preparation and includes findings from a comparison study and analyses of cost and services data on the total population.

Study of the Virginia Pre-Admission Screening Program

Project No.: 18-P-98080/3-01
Period: August 1981 - March 1983
Funding: $ 99,880
Grantee: Virginia Commonwealth University
Richmond, Va.
Project Officer: Marni Hall
Division of Economic Analysis

Description: This is a followup study of Virginia's pre-admission screening program for nursing home placement. Research will compare the family supports available and costs of care for two groups of nursing home residents and two groups of community residents using long-term care services.

Status: Preliminary findings indicate that during the 18-month period of the study:

- No detrimental effects, such as an increase in mortality or decline in functional status, were found to occur that could not be explained by initial differences among the groups.

- The screened denial group continues to cost the Medicaid program less than the approval group despite increasing rates of institutionalization. Moreover, they appear to experience no deleterious effects that would indicate needed services were denied.

The final report was due Summer 1983.

Social Health Maintenance Organization Project for Long-Term Care

Project No.:	18-P-97604/1-04
Period:	March 1980 - May 1986
Funding:	$ 1,553,478
Grantee:	Brandeis University University Health Policy Consortium Waltham, Mass.
Project Officers:	Tom Kickham and Sidney Trieger Division of Long-Term Care Experimentation

Description: The purpose of this project is to develop and implement the concept of a social health maintenance organization (S/HMO) for long-term care. An S/HMO integrates health and social services under the direct financial management of the provider of services. All services would be provided by or through the S/HMO at a fixed annual prepaid capitation sum.

Status: Four S/HMO demonstration sites have been selected by the University Health Policy Consortium (UHPC). These sites include two HMO types that will be adding long-term care services to their service packages, and two long-term care providers that will be adding acute care services to their service packages. UHPC has been successful in assisting the sites in obtaining private foundation funding to finance the development period. UHPC is currently working with the sites on developing a common service package, financing plans, and risk-sharing arrangements.

Multipurpose Senior Services Project

Project No.:	11-P-97553/9-04
Period:	October 1979 - September 1983
Grantee:	State of California Health and Welfare Agency Sacramento, Calif.
Project Officer:	Michael J. Baier Division of Long-Term Care Experimentation

Description: The purpose of this project is to reduce client hospital and skilled nursing facility days, to reduce total expenditures by social and health services for clients, and to improve clients' functional abilities. Service delivery is administered through eight separate demonstration sites located throughout the State. Each site has an average of 60 organizations with which they contract for the provision of direct services to clients. A wide range of waivered health and social services are provided under the project.

Status: The project is in its fourth and final year. Service delivery under the demonstration ended June 30, 1983, for the 1,900 experimental clients (a comparison group of 2,500 clients was also maintained by the project). The grantee secured approval of a section 2176 home and community-based waiver program beginning July 1, 1983. A final report for the demonstration is expected in Fall 1983.

Demonstration of Community-Wide Alternative Long-Term Care Model

Project No.:	11-P-90130/2-08
Period:	July 1976 - July 1983
Funding:	$ 960,938
Grantee:	New York State Department of Social Services Albany, N.Y.
Project Officer:	William Saunders Division of Long-Term Care Experimentation

Description: The New York State Department of Social Services is demonstrating alternative approaches to delivering and financing long-term care to the adult disabled and elderly Medicaid population of Monroe County, New York. The project has developed the Assessment for Community Care Services (ACCESS) model as a centralized unit responsible for all aspects of long-term care for Monroe County residents 18 years of age or over who are eligible for Medicaid and have long-term health care needs. ACCESS staff provides each client with comprehensive needs-assessment and case-management services.

Status: The project received waivers to permit provision of certain community long-term care services not normally provided under Medicaid in New York. Since the project became operational in 1977, more than 18,000 people with potential long-term care needs have received assessments under this program.

Continued Demonstration of a Long-Term Care Center Through Inclusion and Expansion of Title XVIII

Project No.:	95-P-97254/2-03
Period:	August 1980 - July 1984
Funding:	$ 1,802,768
Grantee:	Monroe County Long-Term Care Program, Inc. Rochester, N.Y.
Project Officer:	William Saunders Division of Long-Term Care Experimentation

Description: The purpose of this demonstration is to expand the alternative long-term care delivery model Assessment for Community Care Services (ACCESS)

developed for the Medicaid population in Monroe County, New York, to include the county's Medicare population. The addition of this Medicare project is for the purpose of working toward an integration of Medicare and Medicaid long-term care services.

Status: The development phase of this demonstration was completed, and the project began operations in October 1982. The Health Care Financing Administration has contracted with New York Blue Cross to serve as Medicare fiscal intermediary for the demonstration. Thus far, more than 1,700 Medicare beneficiaries with potential long-term care needs have received assessments from the project.

Home Services for Functionally Disabled Adults

Project No.: 18-P-97462/2-03
Period: June 1980 - June 1984
Funding: $ 488,075
Grantee: Community Service Society
New York, N.Y.
Project Officer: Marni Hall
Division of Economic Analysis

Description: Functionally disabled, low-income adults are being followed for 12 months after acute hospitalization to determine the impact of ongoing home service programs. Access to services, quality of services delivered, participation of informal supports, quality of circumstances, durability of independent living arrangements, and public costs will be examined.

Status: Most of the survey data for this project has been collected. The project is in the process of obtaining patient-specific Medicare and Medicaid utilization data. Analysis of data is underway and some preliminary reports have been completed.

New York State's Long-Term Home Health Care Program

Project No.: 11-P-97155/2-05
Period: September 1978 - September 1983
Funding: $225,688
Grantee: New York State Department of Social Services
Albany, N.Y.
Project Officer: Leslie Saber
Division of Long-Term Care Experimentation

Description: This program provides an alternative to institutionalization for Medicaid clients who meet the medical criteria for skilled nursing facilities (SNF's) or Intermediate Care Facilities (ICF's). A maximum expenditure for home care has been set at 75 percent of the going rate in a locale for SNF or ICF levels of care for which the client is eligible. The program objectives include promoting cost containment by reducing fragmentation in the provision of home care services through a single entry system that coordinates and provides these services.

Status: By the end of the fourth project year, 17 provider sites were operating and the caseload had reached 983 patients. The Health Care Financing Administration approved the project's fifth and final year through September 29, 1983. The final year allows time to complete reassessments, prepare a final report, transmit data to the evaluator, and expand the program Statewide under the authority of Section 2176 (Home and Community-Based Services Program). In December 1982, the program began Statewide expansion.

Evaluation of New York State's Long-Term Home Health Care Program

Project No.: 500-79-0052
Period: September 1979 - January 1984
Funding: $ 742,694
Contractor: Abt Associates, Inc.
Cambridge, Mass.
Project Officer: Kathy Ellingson
Evaluative Studies Staff

Description: The Long-Term Home Health Care Program (LTHHCP) is designed to offer coordinated comprehensive home health care services through a single health care provider to Medicaid-eligible aged or disabled individuals in need of skilled nursing or health-related facility care. The major evaluation objective is to determine whether or not the LTHHCP provides an alternative to institutional care in terms of cost, service use, and quality of care. The research is designed to identify 700 program participants and 700 matched comparison participants, and follow the individuals for at least 1 year by collecting cost and utilization data and applying a health assessment instrument at three points in time. The data being collected are Medicare, Medicaid, Title XX, food stamps, energy assistance, public assistance, and supplemental security income. The final analysis will compare total public expenditures for the program participants to those of the comparison population, with measures of health status outcome for both groups.

Status: A descriptive analysis of the program was completed in March 1983. This report is the case study portion of the final report due in January 1984.

South Carolina Community Long-Term Care Project

Project No.: 99-P-97493/4-04
Period: September 1979 - September 1984
Grantee: Department of Social Services
Columbia, S.C.
Project Officer: Leslie Saber
Division of Long-Term Care Experimentation

Description: Through Medicaid and Medicare waivers, the State is conducting a demonstration in three counties to test community-based client assessment, coordination of services, and provision of alternative services. It is anticipated that these waivers will increase the use of home care services, thereby reducing reliance on hospitals and lowering the incidence of conversion from Medicare to Medicaid in nursing homes.

Status: The project currently has 651 experimental clients and 535 control group clients. In December 1982, the Health Care Financing Administration approved the State's request for a 2-year continuation through September 1984. The State began implementation of the Medicare waivers in Spring 1983. The project has completed two reports--one on project activities in fiscal year 1980-81, and another on nursing home utilization in the project area. One of the findings from the nursing home study was that, among all project patients, 43 percent of the experimental group clients entered a nursing home at some time during the first year, compared with 57 percent of the control group. A final evaluation report is expected in Fall 1984.

Modifications of the Texas System of Care for the Elderly: Alternatives to the Institutionalized Aged

Project No.: 11-P-97473/6-04
Period: January 1980 - December 1985
Grantee: Department of Human Resources
Austin, Tex.
Project Officer: Michael J. Baier
Division of Long-Term Care Experimentation

Description: The purpose of this project is to reduce the growth of nursing homes in Texas and, at the same time, expand access to community care services for needy Medicaid individuals. It is being accomplished by directly changing the operating policies of the State's Title XIX and XX programs; in particular, by eliminating the State's lowest level of institutional care--intermediate care facility (ICF) II. Existing organizations responsible for the State's Title XIX and XX programs are responsible for project implementation.

Status: The project is in its fourth year. Of the 15,302 individuals in the "Intermediate Care Facility-II Cohort" group in March 1980, only 7,458, or 49 percent, were still receiving ICF-II services as of January 31, 1983. The total nursing home population also decreased 11 percent from March 1980 to January 31, 1983, from 64,643 clients to 57,305 clients. The grantee estimates that this project has resulted in a savings of $131 million when a comparison is made between the projected and the actual costs of long-term care services during the period March 1980 through January 31, 1983.

Long-Term Care Demonstration Project of North San Diego County

Project No.: 95-P-97325/9-04
Period: September 1979 - December 1983
Funding: $ 1,063,463
Grantee: Allied Home Health Association, Inc.
San Diego, Calif.
Project Officer: Michael J. Baier
Division of Long-Term Care Experimentation

Description: The purpose of the project is to demonstrate that a Medicare-certified provider of home health services is an appropriate and cost-effective resource for the administration of a long-term care system. The project is comparing client benefits

and costs between existing long-term care services and those provided under the project for 500 Medicare beneficiaries. Case-management and client-assessment services are provided by the grantee and waivered services are provided by 19 suppliers of health and social services.

Status: The project is in its fourth and final year. During the fourth year, emphasis has been placed on evaluation activities and winding down the project. As of June 13, 1983, there were 375 experimental clients and 167 control clients remaining from the full caseload of 500 experimental and 250 control group clients. A final report for the project is scheduled to be completed by January 1984.

Delivery of Medical and Social Services to the Homebound Elderly: A Demonstration of Intersystem Coordination

Project No.: 18-P-97492/2-03
Period: November 1979 - March 1984
Funding: $ 599,358
Grantee: New York City Department for the Aging
New York City, N.Y.
Project Officer: Michael J. Baier
Division of Long-Term Care Experimentation

Description: The purpose of the project is to document the characteristics of a homebound elderly population in New York City, assess their health care needs, and estimate the costs of delivering needed care. A coordinated health care delivery model has been established to carry out this project on behalf of the 400 experimental Medicare clients. The project organization includes a project advisory committee that is comprised of representatives of relevant city departments, and four neighborhood-based service delivery sites.

Status: The project is in its third and final year and is scheduled to terminate on March 31, 1984. On April 1, 1983, the project began discharging clients for whom it was able to arrange alternate services in the community. A final report is expected by December 1983.

Long-Term Care Demonstration Design and Development

Project No.: 95-P-97231/9-04
Period: September 1978 - September 1983
Funding: $ 1,243,368
Grantee: Mt. Zion Hospital and Medical Center
San Francisco, Calif.
Project Officer: William Saunders
Division of Long-Term Care Experimentation

Description: The Mt. Zion Hospital and Medical Center is conducting this Medicare demonstration to implement a hospital-based, long-term care services delivery system in a designated service area in San Francisco, Calif. This model builds upon components of Mt. Zion's existing geriatric services program. A consortium of five service providers under the direction of Mt. Zion cooperate to provide a range of health and social services to the frail elderly in the designated catchment area.

Status: The project has received waivers to permit provision of certain health-related and social services that are not otherwise provided under Medicare. The project became operational in August 1980, and by August 1981, had reached its projected caseload of 200 experimental group members and 100 control group members. The operational phase of the project ended on June 30, 1983. The final report is expected in Fall 1983.

Ancillary Community Care Services: A Health Care System for Chronically Impaired Elderly Persons

Project No.: 11-P-97438/4-04
Period: October 1979 - September 1983
Grantee: Department of Health and Rehabilitation
Tallahassee, Fla.
Project Officer: Leslie Saber
Division of Long-Term Care Experimentation

Description: The State is conducting a Medicaid demonstration project in five counties. The purpose of the project is to develop and test ancillary community care services for the chronically impaired elderly 60 years of age and over. All eligible clients receive a comprehensive medical-social assessment administered by a physician and social worker. The participating counties are responsible for developing client-care plans based on the assessment, conducting case management, and contracting for services with local providers.

Status: The total number of project participants is 971, with 761 randomly assigned to the experimental group and 210 assigned to the control group. All sites reached full caseload by June 1982. The project is currently in its fourth and final year. Beginning in April 1983, the project sites will work with community agencies to develop an orderly plan for transferring clients from the project to the existing service delivery system. In May, the State submitted an iterim report describing the project's research design and base-line data. The final evaluation report will be submitted in March 1984.

Swing Bed

Reducing Acute Care Costs

Project No.: 600-75-0207
Period: July 1975 - September 1983
Funding: $ 148,535
Contractor: Blue Cross of Western Iowa and South Dakota
Sioux City, Iowa
Project Officer: Tom Kickham
Division of Long-Term Care Experimentation

Description: This project is a swing-bed demonstration that seeks to reduce a hospital's acute care costs while alleviating two problems prevalent in many rural communities: low occupancy rates in the hospital and a shortage of long-term care beds. Essentially, the experiment allows a hospital to use existing staff and facilities to render both acute and long-term care.

Status: Based on the results of swing-bed demonstrations, legislation was introduced in Congress and enacted as part of the Omnibus Reconciliation Act of 1980 (Public Law 96-499) to permit reimbursement of swing-bed care in rural hospitals with less than 50 beds. Regulations implementing this legislation were published on July 20, 1982. Waivers were extended until November 20, 1982, to allow participating hospitals to meet the requirements of the legislation.

Quality

Improving New York State's Nursing Home Quality Assurance Program

Project No.: 11-P-97590/2-03
Period: September 1980 - September 1983
Grantee: State of New York Department of Social Services
Albany, N.Y.
Project Officer: Elizabeth S. Cornelius
Division of Long-Term Care Experimentation

Description: This project tests the simplification of federally mandated periodic medical review/independent professional review processes in nursing homes and combines the process with the annual facility survey. Surveyors use 11 sentinal health events (SHE), such as accidents, decubitus ulcers, and medication regimen to determine if nursing home patients are receiving quality care. Facilities found to have fewer than the average problems in these areas receive a less than full facility survey. This combined medical review and survey method reduces surveyors' time and allows State personnel to focus on facilities and patients with major problems.

Status: The project is currently in its third and final year. The new inspection-of-care processes are fully operational. The State has indicated that it is taking more legal actions than usual as a result of the new processes, but that fewer facilities are being cited for minor problems. During the third year, the project staff will continue to monitor the implementaion of the new methods and integrate them with the new survey process. Plans will be completed to use the Form DMS-1 (Division of Medical Services) for Stage I screening of some SHE's when the system becomes operational.

Survey by Exception

Project No.: 11-P-97731/1-02
Period: June 1980 - September 1982
Grantee: Massachusetts Department of Public Welfare
Boston, Mass.
Project Officer: Elizabeth S. Cornelius
Division of Long-Term Care Experimentation

Description: The purpose of this project is to develop and test a method of conducting nursing home surveys so that the intensity of the regulatory effort is matched to the needs of particular facilities. The facilities are grouped according to past performance and the attention is then given to the poorer performers.

Status: The demonstration phase of the project is completed. The State was given permission by the Health Care Financing Administration (HCFA) Regional Office to continue the Survey by Exception methods in most homes. The State has also maintained the control facilities for study by the evaluation contractor. Massachusetts submitted the final report to HCFA for review in Summer 1983.

Quality Assurance Sampling: A Statistical Quality-Control Approach to Inspection of Care

Project No: 11-P-98260/1-01
Period: March 1983 - February 1986
Grantee: Massachusetts Department of Public Welfare
Boston, Mass.
Project Officer: Elizabeth S. Cornelius
Division of Long-Term Care Experimentation

Description: The main objective of the project is to verify that patients in nursing homes are receiving appropriate care at the appropriate level, without reviewing every patient. Current law requires a review of all patients in a facility to verify the apropriatness of care and placement. This project will use statistical quality control techniques to achieve these goals so that surveyor time can be reallocated to other quality-assurance activities.

Status: Criteria has been developed for determining which facilities are appropriate for the sampling process. The procedures for sampling patients, including safeguards to control statistical biases, have been refined. Pre-tests of the process and orientation sessions for surveyors have been scheduled for July 1983.

Evaluation of Three-State Demonstration in Nursing Home Quality Assurance

Project No.: 500-82-0024
Period: August 1982 - August 1984
Funding: $ 444,322
Contractor: Mathematics Policy Research
Madison, Wis.
Project Officer: Spike Duzor
Evaluative Studies Staff

Description: This is an evaluation of the three-State demonstration testing new procudures for conducting nursing home facility surveys and patient quality of care determinations. The States participating in this demonstration include Wisconsin, New York, and Massachusetts.

Status: The contractor is currently collecting data to measure the results of the survey process in nursing homes that were surveyed using the new methods and a group of comparison homes where the old survey methods were used. A final report is expected in September 1984.

Data Development and Analyses

Interagency Agreement for Long-Term Care Survey of Individuals in Households

Project No.: IAA-82-0159
Period: October 1981 - September 1984
Funding: $ 975,000
Contractor: Assistant Secretary for Planning and Evaluation
Department of Health and Human Services
Washington, D.C.
Project Officer: Allen Dobson
Office of Research

Description: When the limited budget necessitated a cutback in the Department of Health and Human Services' overall long-term care survey efforts, this project was initiated to provide information on functionally-limited elderly individuals living in households. A sample of 35,000 aged persons was drawn from the Health Care Financing Administration's Health Insurance Master File and was screened by telephone or personal visits to identify individuals having functional limitations for a period of 3 months or longer. The 6,400 functionally-limited persons so identified were interviewed to ascertain information on their limitation, on the formal and informal network supporting them, and on their income.

Status: Data collection was completed in October 1982. Data for analysis was available in Summer 1983. A series of reports is planned which will provide: the number, distribution, and the demographic and functional characteristics of disabled persons in households; sources and nature of support in carrying out the activities of daily living; income and assets; and use of medical services.

Long-Term Care Residential Services for Developmentally Disabled People

Project No.: 18-P-98078/5-02
Period: September 1981 - September 1984
Funding: $ 1,166,635
Grantee: University of Minnesota
Minneapolis, Minn.
Project Officer: Marni Hall
Division of Economic Analysis

Description: This project will update the only national information system on long-term care services for the mentally retarded and developmentally disabled (MR/DD). Data will be gathered on characteristics of residents and facilities, including intermediate care facilities for the mentally retarded. Data from this study will be used to track the effects of recent State deinstitutionalization policies. As part of the project, policy analyses of the cost/utilization of Medicaid MR/DD services are made. These analyses focus on: financing of residential care, case mix and movement of residents, and programs, services, and manpower.

Status: Data from the national survey of residential facilities are being processed. The annual survey of State mental retardation program directors has been fielded. An analysis of State responses to Section 2176, Public Law 97-135, as it impacts on the mentally retarded, is near completion. The following four reports and 13 papers have been accepted for publication in professional journals:

- "An Analysis of State Respondents to the Home and Community-Based Waiver Program."
- "Day Programs and Services Received by Mentally Retarded People in Residential Facilities."
- "Environmental Characteristics of Residential Facilities for Mentally Retarded People."
- "Mentally Retarded People in State-Operated Residential Facilities: Years Ending June 30, 1981 and 1982."
- "New Admissions and Readmissions to a National Sample of Public Residential Facilities," American Journal on Mental Deficiency.
- Maladaptive Behavior of Mentally Retarded People in Residential Facilities," American Journal on Mental Deficiency.
- "Physical and Behavioral Characteristics of Mentally Retarded People," Journal of Health and Social Work.
- "Changes in Age at First Admission to Residential Care for Mentally Retarded People," Mental Retardation.
- "Response to the General Accounting Office Report to Congress, 'Disparities Still Exist in Who Gets Special Education,'" Exceptional Children.
- "Resident Release Patterns in a National Sample of Public Residential Facilities," American Journal of Mental Retardation.
- "Deinstitutionalization and Foster Care: A National Study," Health and Social Work.
- "Placement of Mentally Retarded Residents from Public Residential Facilities in the United States," Perspectives and Progress in Mental Retardation.
- "Family Leisure and Social Activities of Mentally Retarded People in Residential Facilities," Journal of Social Work.
- "One Hundred Years of Data on Populations of Mentally Retarded People in Public Residential Facilities," American Journal on Mental Deficiency.
- "Turnover of Direct-Care Staff in a National Sample of Residential Facilities for Mentally Retarded People," American Journal on Mental Deficiency.

- "Factors Related to Job Stability of Direct-Care Staff of Residential Facilities for Mentally Retarded People," Journal of Community Psychology.

- "Sex as a Bona Fide Occupational Qualification for Direct-Care Staff in Residences for Mentally Retarded People," Mental Retardation.

Home Health Aides

Period: January 1982 - June 1986
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Description: Recipients of Aid to Families with Dependent Children (AFDC) are trained and employed as homemakers/home health aides to provide services to elderly or disabled individuals who, without this support, would require institutionalization. The objectives of the demonstration are to reduce welfare dependency and to prevent or delay the institutional placement of the eligible service clients. This study will measure the costs and benefits of the program, including its contribution to the improvement in employment and earnings capacity of the AFDC recipient and the reduction in the need for institutional care of the functionally impaired home care service client.

Status: Seven States are participating in this demonstration which initiated its 3-year operational segment on January 1, 1983. At that time, some of the States began the process of recruiting and training eligible AFDC recipients to provide home care services to elderly and/or disabled service clients. Many of these first trainees have successfully completed the curricula prescribed by the States and are now employed as homeworker/home health aides.

A Plan for Employing AFDC Recipients as Homemaker/Home Health Aides to Provide Alternatives to Long-Term Care

Project No.: 12-P-98110/6-02
Grantee: Arkansas Department of Human Services
Little Rock, Ark.

Preventacare: An Alternative to Institutionalization

Project No.: 12-P-98111/4-02
Grantee: Kentucky Cabinet for Human Resources
Frankfort, Ky.

AFDC Homemaker/Home Health Aide Demonstration Project

Project No.: 12-P-98113/2-02
Grantee: New Jersey Department of Human Services
Trenton, N.J.

New York State AFDC Homemaker/Home Health Aide Demonstration

Project No.: 12-P-98103/2-02
Grantee: New York State Department of Social Services
Albany, N.Y.

Employment Opportunity for AFDC Recipients in the Homemaker/Home Health Aide Field

Project No.: 12-P-98106/5-02
Grantee: Ohio Department of Public Welfare
Columbus, Ohio

Homemaker/Home Health Aide Project

Project No.: 12-P-98108/4-02
Grantee: South Carolina Department of Social Services
Columbia, S.C.

AFDC Recipients as Providers of Services to Aged and Disabled

Project No.: 12-P-98104/6-02
Grantee: Texas Department of Human Resources
Austin, Tex.

Design Development and Evaluation of the AFDC Homemaker/Home Health Aide Demonstration Project

Project No.: 500-82-0022
Period: June 1982 - June 1986
Funding: $ 454,174
Contractor: Abt Associates, Inc.
Cambridge, Mass.
Project Officer: Kathy Ellingson
Office of Demonstrations and Evaluations

Description: The purpose of this project is to evaluate the Aid to Families with Dependent Children (AFDC)/Homemaker Home Health Aide demonstration and to provide technical assistance to the seven States participating in the demonstration. The actual evaluation will occur under separate contracts with the seven participating States. The three major evaluation objectives are to:

- Assess the costs and effectiveness of the training and employment of AFDC recipients as homemakers/home health aides on subsequent, continued, and nonsubsidized employment.
- Assess the costs and outcomes of providing home health aid services to persons at risk of institutionalization who would otherwise not receive these services.
- Assess the net cost effectiveness and provide policy-relevant projections on large-scale implementation.

Status: The contractor has completed four major deliverables: a data resources report; a report on issues in the design implementation; the final research design; and the first year report, "Planning and Initial Implementation Experience." This report is a descriptive analysis of the seven States' first year activity. Individual State case studies were also completed.

Other Long-Term Care

Bioactuarial Estimates and Forecasts of Health Care Needs and Disability

Project No.: 18-P-97710/4-03
Period: June 1980 - August 1984
Funding: $ 428,650
Grantee: Duke University
Durham, N.C.
Project Officer: Larry Corder
Division of Economic Analysis

Description: This project employs bioactuarial methods to estimate the need for various types of health services including long-term care. The determinations of levels of need are employed in analyses of the health status of small geographic areas as well as in national projections. The project is also examining how need estimates are being translated into utilization of nursing homes. These applications of bioactuarial strategies for forecasting population change in health status represent an extension of the grant's basic work.

Status: Results of this project include estimates and projections of the incidence of specific chronic diseases (for example, cancer) prevalent among the elderly population. In addition, the study has provided new insights on the flow of the elderly population through the nursing home system (for example, admission rates and lengths of stay). Finally, the project is developing profiles of the elderly population in terms of the likelihood of their using alternative modes of long-term care. The National Medical Care Utilization and Expenditure Survey and the Long-Term Care Survey, both Health Care Financing Administration funded efforts, have had this methodology applied to them.

Development of Patient Classification of Resource Utilization in Long-Term Care

Project No.: 18-P-97757/1-01
Period: January 1981 - January 1983
Funding: $ 100,000
Grantee: Yale University
New Haven, Conn.
Project Officer: Philip Cotterill
Division of Economic Analysis

Description: The purpose of this project was to identify groups of nursing home patients according to their resource consumption. The patient groups were based on combinations of health status characteristics, and resource consumption was measured in terms of nursing staff time.

Status: The study found that for the sample of patients drawn from 36 Connecticut nursing homes, nine resource utilization groups were capable of reducing the variation in nursing staff time by 37 percent. Findings from the study led the investigators to suggest that resource utilization groups can be useful for incorporating patient characteristics in case-mix related reimbursement strategies.

Impact of State Discretionary Policies

Project No.: 18-P-97620/9-03
Period: March 1980 - December 1983
Funding: $ 917,268
Grantee: University of California
San Francisco, Calif.
Project Officer: Marni Hall
Division of Economic Analysis

Description: This is a study of discretionary State policies in Medicare/Medicaid, Title XX, and Supplemental Security Income as they affect long-term care (LTC) services for the aged. Particularly important in the research are the effects that actual or perceived fiscal crisis has on long-term care services. By comparing various States' LTC policies, data about optional approaches to containing LTC costs will be obtained.

Status: Case studies on each of eight study States have been completed. Personal interviews and a telephone survey of State officials and providers were important sources of information for these case studies. A report that compares policies among the eight study States is in process.

Comparison of the Cost and Quality of Home Health and Nursing Home Care

Project No.: 18-P-97712/8-03
Period: June 1980 - January 1985
Funding: $ 1,225,359
Grantee: University of Colorado
Denver, Colo.
Project Officer: Philip Cotterill
Division of Economic Analysis

Description: This study assesses the cost, quality, and cost-effectiveness of nursing home and home health care provided by free-standing agencies and hospital-based facilities. Detailed data on patient conditions and services were collected for a sample of nursing home and home health patients from the following States: Arkansas, California, Colorado, Florida, Michigan, Minnesota, New York, Ohio, Pennsylvania, and Virginia. A subset of patients will be tracked over time to observe outcomes.

Status: Major research design and data collection activities have been completed. The third year activities include initial cost-effectiveness comparisons among the various care modalities. Preliminary results indicate significant case-mix differences between hospital-based and free-standing nursing homes, but no significant case-mix differences between hospital-based and free-standing home health agencies.

Hospital-based nursing patients tend to have more medical problems and fewer psychosocial problems than do patients in free-standing nursing homes. These results apply largely to Medicaid patients. Case-mix comparisons of Medicare and non-Medicare patients are in progress.

Pursuit of Institutional Alternatives

Project No.: 18-P-98188/4-01
Period: December 1982 - December 1983
Funding: $ 242,478
Grantee: North Carolina Health Care Facilities Association
Raleigh, N.C.
Project Officer: Marni Hall
Division of Economic Analysis

Description: This study explores the potential participation of North Carolina nursing homes in alternative institutional programs that provide services to the elderly. Alternative programs to be examined include home health care, adult day care, and nutritional services. The legal, organizational, financial, and facility resource requirements will be identified. This project will also assess the changes in demand for noninstitutional long-term care services as a result of the Medicaid home and community-based waivers authorized under Section 2176 of the Omnibus Budget Reconciliation Act of 1981.

Status: This project was initiated in December 1982.

Encouraging Appropriate Care for the Chronically Ill Elderly: A Controlled Experiment to Evaluate the Impacts of Incentive Payments on Nursing Home Admissions, Discharges, Case-Mix, Care, Outcomes, and Costs

Project No.: 11-P-97931/9-02
Period: April 1981 - April 1985
Grantee: California Department of Health Services
Sacramento, Calif.
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Description: The California Skilled Nursing Incentive Payment Project is designed to test a system of monetary incentives as a means of encouraging skilled nursing facilities (SNF's) in San Diego to admit and provide quality care to severely dependent patients. Many patients have more lengthy hospital stays than appropriate because of the amount and cost of care these patients would require in an SNF. Health Care Financing Administration waivers are necessary so that the State may set nursing home rates which exceed the Medicaid reasonable cost requirements by the amount of the incentive payment.

Status: Preliminary results regarding admission incentives are mixed. During the study period, the proportion of Type E patient admissions (patients requiring special

nursing, such as comatose care) to treatment group SNF's rose from 6.8 percent to 11 percent, and the proportion of Type E admissions to control group SNF's dropped slightly from 6.1 percent to 5.7 percent. Type D patient admissions (those dependent in all six activities of daily living) remained unchanged for both treatment and control groups.

Effects of Alternative Family Support Strategies

Project No.: 95-P-98281/0-01
Period: May 1983 - April 1986
Funding: $ 396,531
Grantee: University of Washington Institute of Aging
Seattle, Wash.
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Description: The purpose of this project is to study the effects of support programs provided to families that care for their elderly members at home. The demonstration will assess the impact of three support strategies: paid respite care, family training and education, and a combination of training with respite care. Key outcome variables to be measured are family burden, the length of time family members continue to serve as primary care givers, propensity toward institutionalization, and the cost of long-term care support services.

Status: This project is in its developmental phase. Families will begin receiving services on January 1, 1983.

Analysis of Long-Term Care Payment Systems

Project No.: 18-P-98306/8-01
Period: April 1983 - April 1987
Funding: $ 1,358,011
Grantee: University of Colorado Health Sciences Center
Denver, Colo.
Project Officer: Philip Cotterill
Division of Economic Analysis

Description: This project is a comparative analysis of long-term care reimbursement systems in eight States. The study will combine an empirical analysis of nursing home costs and payments and the determinants of costs with a detailed qualitative analysis of the operations of the reimbursement systems. The comparative analysis across States will be performed through a unique "comparison-by-substitution" method that calculates reimbursement for nursing homes in one State under the assumption that the other States' reimbursement systems are in effect. Data sources for this study include primary facility information and patient samples, as well as secondary sources such as cost reports.

Status: The initial work during the first 3 months of the study focused on review of State nursing home reimbursement systems and refinement of the study's research design.

Comparison by State of SNF/ICF Types: Beds, Staffing, Utilization, and Ownership

Funding: Intramural
Project Director: Elizabeth S. Cornelius
Division of Long-Term Care Experimentation

Description: This project will provide an unduplicated count of skilled nursing facilities (SNF's), intermediate care facilities (ICF's), and respective beds for 1981. The facility and bed count will be based on the Medicare/Medicaid Automated Certification System (MMACS) data. Full-time equivalents for registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, pharmacists, qualified social workers, and dietitians will also be identified. A staffing matrix showing the relationship to current staffing regulations will be developed. In addition, a staffing matrix, using number of beds to nurse staffing ratios will be tested. This project is being conducted in conjunction with a project funded by the Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, which will evaluate the usefulness of the MMACS system for research and policy analysis purposes. The intramural analysis will examine State-by-State differences in:

- Types of certified long-term care facilities (SNF only, SNF/ICF combination, ICF only).
- Number of beds per facility.
- Professional staffing levels.

The State will also identify the percent of total certified beds used by Medicare, Medicaid SNF, and Medicaid ICF, during Fiscal Year 1981.

Status: An unduplicated tape has been prepared and tables have been constructed. The staffing data is currently being cross checked with the Master Facility Inventory file maintained by the National Center for Health Statistics.

Competition

A Demonstration of Cost Control and Patient Satisfaction Resulting from the Relaxation of the Maximum Public Enrollment Rule for HMO's

Project No.: 11-P-97986/5-02
Period: April 1981 - March 1984
Grantee: Michigan Department of Social Services
Lansing, Mich.
Project Officer: Eric R. Nevins
Division of Health Systems and Special Studies

Description: The purpose of this demonstration is to test the effects on the cost and quality of care in health maintenance organizations (HMO's) resulting from the relaxation of the regulation requiring that Medicare and Medicaid beneficiaries cannot exceed 75 percent of total HMO enrollment. The project will compare the quality of care provided in HMO's exceeding the limit with HMO's conforming to the regulation through the use of satisfaction surveys.

Status: The project has developed a survey instrument modeled after the one used in the Prepaid Health Research, Evaluation, and Demonstration project (Project No. 96-P-90299/9). The survey questionnaire measures patient satisfaction in relation to seven health care dimensions, in addition to demographics and health care expenses. The State is in the process of evaluating the survey results.

Competitive Bidding for Clinical Laboratory Services

Project No.: 500-82-0054
Period: September 1982 - August 1983
Funding: $ 182,318
Contractor: Center for Health Policy Studies
Columbia, Md.
Project Officer: Diane L. Rogler
Division of Hospital Experimentation

Description: The purpose of this 1-year contract is to develop a competitive bidding system for clinical laboratory services. The contract involves a mini-market study to collect and evaluate information about the laboratory industry from three sites, followed by a series of papers addressing the various issues which are important to the design of a bidding system. The end products include a comprehensive description of the competitive bidding system, an implementation strategy, and the documents necessary to solicit bids for Medicare and/or Medicaid.

Status: The mini-market study report and six of the eight issue papers have been submitted. The Center will complete the remaining issue papers and begin drafting the final deliverables. The contract was scheduled to be completed by the end of August 1983.

Evaluation of Health Maintenance Organization (HMO) Capitation Demonstrations

Project No.: 500-81-0017
Period: February 1981 - August 1984
Funding: $ 2,272,672
Contractor: Jurgovan and Blair, Inc.
Rockville, Md.
Project Officer: Alan Friedlob
Evaluative Studies Staff

Description: This evaluation examines the experience of eight health maintenance organizations (HMO's) who have contracted with the Health Care Financing Administration (HCFA) under a pre-paid at-risk basis to provide services to Medicare beenficiaries. These demonstrations are the precursors of current legislation contained in the Tax Equity and Fiscal Responsibility Act of 1982, section 114. The evaluation's objectives are:

- To measure HMO versus fee-for-service differences in utilization patterns for Medicare beneficiaries, standardizing for population differences.
- To assess the accuracy of HCFA's method of estimating what HMO enrollees would have cost under fee-for-service (that is, for the adjusted average per capita cost).
- To measure the extent to which either favorable or adverse selection has occurred, and the cost impact of selection bias in enrollment.
- To assess the cost effectiveness of different marketing methods to the Medicare beneficiary population.
- To assess the fiscal impact of the demonstrations for HCFA, for the HMO, and for beneficiaries.
- To examine the organizational changes in both the administrative and delivery systems conditioned by the addition of seniors to HMO membership.
- To analyze the implications of the demonstrations for national policy.

Status: The actuarial critique was completed in April 1982 and circulated within HCFA. A survey of Medicare beneficiaries who joined the plans and those who chose not to enroll has been completed in Marshfield, Wis., Worcester, Mass., and Minneapolis-St. Paul, Minn. Survey findings will be available Fall 1983. A major report, integrating survey and utilization analyses at Fallon, Marshfield, Kaiser, and the Twin Cities (survey only) demonstration sites will be produced in Spring 1984.

Evaluation of the Arizona Health Care Cost Containment System

Project No.: 500-83-0027
Period: June 1983 - September 1986
Funding: $ 2,489,488
Contractor: SRI International, Inc.
Menlo Park, Calif.
Project Officer: Richard Yaffe
Evaluative Studies Staff

Description: This project will evaluate the implementation, operation, and impact of the Arizona Health Care Cost Containment System (AHCCCS), which is a unique and innovative State-sponsored demonstration that provides public assistance medical care (medical assistance) to residents of Arizona who are eligible for Aid to Families with Dependent Children and Supplemental Security Income cash payments. The study will focus on measuring the effects of AHCCCS on cost, quality, and utilization of health care as well as issues related to patient access and satisfaction. The following major innovative cost-containment methods, which are unique to Arizona among all State Medicaid Programs, will be evaluated:

- Capitation prepayment contracts, awarded as a result of competitive bidding, to health care plans that provide or arrange for the provision of covered services.
- "Gatekeeping" by a primary care physician who will be responsible for either providing or authorizing the services to be reimbursed for the enrollees, including any services provided by specialists.
- Use of nominal copayments as a means of inhibiting unnecessary utilization.
- Restriction on freedom-of-choice of plans and providers.
- Capitated payment of Federal financial participation by the Health Care Financing Administration to the State of Arizona based on the number of enrollees.

Status: The contract to carry out the AHCCCS evaluation was awarded in June 1983.

Medicare Prospective Capitation Demonstration Project

Project No.: 95-P-98147/4-02
Period: April 1982 - March 1986
Grantee: International Medical Centers, Inc.
Miami, Fla.
Project Officer: G. Theodore Saffran
Division of Health Systems and Special Studies

Description: This project will demonstrate and test an alternative to traditional Medicare financing and health care delivery in Miami. The health maintenance organization (HMO) will provide covered Medicare benefits for an amount of reimbursement equal to 95 percent of the adjusted average per capita costs. Extra benefits are being offered to Medicare beneficiaries at little or no cost, including dental benefit, eyeglasses, hearing aides, prescription drugs, and transportation to the HMO.

Status: Preparation for implementation of the demonstration proceeded from April through July 1982. On August 1, 1982, more than 10,000 Medicare beneficiaries were enrolled in the demonstration. These beneficiaries were already enrolled in a Health Care Financing Administration sponsored section 1876 risk contract. Since that time, International Medical Centers (IMC) has averaged more than 1,000 new members per month. As of June 1, 1983, IMC had 20,821 members. Among the operational problems that have arisen, IMC was having difficulty in negotiating arrangements with area hospitals. IMC has now selected a different claims processing option that allows the intermediary to pay claims from those hospitals with which IMC cannot arrange an agreement. This project is scheduled for implementation through December 31, 1985, and IMC expects to expand from the present two counties (Dade and Broward) to other counties within the State of Florida.

Enrollment of Medicare Beneficiaries Under a Unique Intra-Health Maintenance Organization Competition Model

Project No.: 95-P-98215/4-02
Period: September 1982 - August 1986
Grantee: CAC Health Plan, Inc.
Miami, Fla.
Project Officer: G. Theodore Saffran
Division of Health Systems and Special Studies

Description: This project will demonstrate and test an alternative to traditional Medicare financing and health care delivery in Miami. The health maintenance organization (HMO) will provide covered Medicare benefits and several extra benefits for an amount of reimbursement equal to 95 percent of the adjusted average per capita costs. A unique feature of the HMO is an enrollee privilege to seek out-of-plan physician services subject to a deductible and copay amount.

Status: The design phase, including protocol, waiver approval, service agreement development and approval, and marketing material approval was completed within 30 days of grant award and the first enrollees in CAC became effective October 1, 1982. As of June 1, 1983, there were 3,290 Medicare enrollees in the plan. The plan offers extensive benefits in addition to Medicare, with no monthly premium. The service agreement is in effect through December 31, 1986.

Medicare Competition Demonstration

Project No.: 500-82-0037
Period: September 1982 - September 1987
Contractor: Av-Med, Inc.
Miami, Fla.
Project Officer: G. Theodore Saffran
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in Miami. Av-Med is a federally qualified, individual practice association model health maintenance organization (HMO), that has a 5-year contract to implement a full-risk prepaid capitation demonstration project in Dade and Broward Counties, Florida. Av-Med is accepting 95 percent of the adjusted average per capita cost and is providing an expanded benefit package with a monthly premium of $ 24. Av-Med has more than 100 independent practice physicians participating in the demonstration. The HMO intends to enroll at least 5,000 Medicare beneficiaries during each year of the demonstration. They also expect to expand to other Florida counties in 1984.

Status: Av-Med began Medicare demonstration enrollment on November 1, 1982. The entire design phase, that is, protocol development, waivers approval, service delivery contract development and approval, marketing material approval, and implementation of systems changes was completed within 30 days. As of June 1, 1983, more than 1,500 Medicare beneficiaries were enrolled in Av-Med and marketing efforts are continuing.

Medicare Competition Demonstration

Project No.: 500-82-0050
Period: September 1982 - September 1987
Funding: $ 363,524
Contractor: Family Health Program, Inc.
Fountain Valley, Calif.
Project Officer: Eric R. Nevins
Division of Health Systems and Special Studies

Description: This is a project designed to develop and test an alternative model for financing and delivering health care services to Medicare beneficiaries living in southern Los Angeles County and Orange County, Calif. Family Health Program (FHP) is a federally qualified health maintenance organization (HMO) which proposed to compete for area beneficiaries by making available an attractive benefit package. FHP

plans to demonstrate that a clinical facility, designed specifically for a Medicare population, will improve quality of care and is cost effective. Reimbursement will be based on 95 percent of the adjusted average per capita cost.

Status: The developmental phase of this project is estimated to be 12 months, with an open enrollment period scheduled for September 1983. FHP has developed a protocol which details operational procedures such as organizational configuration, plan qualifications, benefits, reimbursement mechanisms, marketing, enrollment procedures, and quality assurance. FHP projects to enroll 10,000 Medicare beneficiaries from the communities of Long Beach and Seal Beach who will receive their care at a specially designed primary care facility.

Medicare Competition Demonstration

Project No.: 500-82-0043
Period: September 1982 - September 1987
Contractor: Watts Health Foundation
Los Angeles, Calif.
Project Officer: Eric R. Nevins
Division of Health Systems and Special Studies

Description: This is a project designed to test an alternative model for enhancing competition among providers of care. United Health Plan (UHP) will implement a competitive demonstration through a contract with the Health Care Financing Administration (HCFA) to provide Medicare beneficiaries in the Los Angeles-Orange county area with a comprehensive set of benefits covering physician services, hospitalization, and other medical services. Reimbursement for services will be prospectively determined on a capitation basis. UHP will also provide all administrative, marketing, quality assurance, and utilization control functions required under this contract.

Status: The developmental phase is estimated to be 12 months, with enrollment beginning in November 1983. The draft protocol was submitted in June. The protocol defines areas such as organizational configuration, plan qualifications, benefits, reimbursement mechanisms, marketing, enrollment procedures, and quality assurance. UHP projects to enroll 4,000 Medicare beneficiaries the first year and to expand to 10,000 beneficiaries by the third operational year.

Medicare Competition Demonstration

Project No.: 500-82-0049
Period: September 1982 - September 1987
Funding: $ 232,835
Contractor: Blue Cross of California
Van Nuys, Calif.
Project Officer: Nancy Row
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in the Santa Barbara area. Reimbursement will be on a

prepaid per capita basis, capitated at 95 percent of the adjusted average per capita cost. Financing will be on a risk basis. Two alternatives will be tested including a preferred provider arrangement.

Status: This project is in its developmental phase. Blue Cross of California has contacted various provider organizations to determine if they will participate. Blue Cross anticipates the project will be implemented in November 1983.

Medicare Competition Demonstration

Project No.: 500-82-0051
Period: September 1982 - September 1987
Funding: $ 980,646
Contractor: Health Choice, Inc.
Portland, Oreg.
Project Officer: Nancy Row
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in the Portland area. Reimbursement will be on a prepaid per capita basis, capitated at 95 percent of the adjusted average per capita cost (AAPCC). Financing will be on a risk basis. Health Choice will establish itself as a broker for Medicare beneficiaries in the county. As broker, it would market to beneficiaries and counsel them as to which alternative health plans (AHP's) are available and what benefits each offer. Health Choice would subcontract to assist organizations in establishing themselves as AHP's.

Status: This project is in its developmental phase. A conference was held in January 1983 with potential provider organizations who would accept risk reimbursement at 95 percent of the AAPCC. A consulting firm will be selected to provide technical assistance to providers. Enrollment is scheduled to begin April 1984.

Medicare Competition Demonstration

Project No.: 500-82-0042
Period: September 1982 - September 1987
Contractor: Maricopa County Department of Health Services
Phoenix, Ariz.
Project Officer: Sidney Trieger
Division of Health Systems and Special Studies

Description: The Maricopa County Department of Health Services (MCDHS) has established an Alternative Health Plan, which is enrolling Medicaid eligibles under the Arizona Alternative Health Care Cost Containment System. MCDHS plans to offer enrollment also to Medicare beneficiaries. They will receive payment from Medicare at 95 percent of the adjusted average per capita cost.

Status: The MCDHS intends to provide a comprehensive range of benefits, including nursing services typically associated with long-term care and not covered by Medicare. The project submitted a draft protocol in August 1983, and has a projected start date of January 1984.

Medicare Competition Demonstration

Project No.: 500-82-0046
Period: September 1982 - September 1987
Funding: $ 565,047
Contractor: Harvard Community Health Plan
Boston, Mass.
Project Officer: Nancy Row
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in the Boston area. Reimbursement will be on a prepaid per capita basis, capitated at 95 percent of the adjusted average per capita cost. Financing will be on a risk basis. Harvard Community Health Plan is a successful, federally qualified, staff model health maintenance organization (HMO) operational since 1969. It is one of 14 HMO's in the project area. It plans to enroll 7,200 Medicare beneficiaries by the end of the demonstration. Benefits competitive with Medigap will be offered at lower premiums.

Status: This project is in its developmental phase. Harvard is reviewing the actuarial cost of the Medicare benefit package to determine what additional benefits can be provided. The project is scheduled to begin enrollment June 1984.

Medicare Competition Demonstration

Project No.: 500-82-0045
Period: September 1982 - September 1987
Funding: $ 531,360
Contractor: Blue Cross of Massachusetts
Boston, Mass.
Project Officer: Nancy Row
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in Massachusetts. Reimbursement will be on a prepaid per capita basis, capitated at 95 percent of the adjusted average per capita cost. Financing will be on a risk basis. Under this demonstration, Blue Cross of Massachusetts will establish a Senior Plan Network of four, and possibly five health maintenance organizations (HMO's) in the State. Each HMO will compete with at least one other in its area.

Status: This project is in its developmental phase. Blue Cross of Massachusetts is developing the necessary systems modification to establish the Senior Plan Network. The project is scheduled to begin enrollment in October 1983.

Medicare Competition Demonstration

Project No.: 500-82-0033
Period: September 1982 - September 1987
Contractor: Rhode Island Group Health Association
Providence, R.I.
Project Officer: Nancy Row
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in the Rhode Island area. Reimbursement will be on a prepaid per capita basis, capitated at 95 percent of the adjusted average per capita cost. Financing will be on a risk basis. This project is with an 11-year old, federally qualified health maintenance organization that serves 35,000 members in parts of Rhode Island and Southeast Massachusetts. It currently has a cost contract under which 2,000 Medicare beneficiaries are enrolled.

Status: This project is in its developmental phase. The contractor is preparing a protocol and expects to begin enrollment by December 1983.

Medicare Competition Demonstration

Project No.: 500-82-0032
Period: September 1982 - September 1987
Contractor: U.S. Health Care Systems Health Maintenance Organization of Pennsylvania
Willow Grove, Pa.
Project Officer: Shelagh Smith
Division of Health Systems and Special Studies

Description: This project will demonstrate and test an alternative to traditional Medicare financing and delivery of health care services in the Philadelphia metropolitan area. The demonstration is a large, established, federally qualified individual practice association model, health maintenance organization (HMO) that serves 105,000 enrollees in the Philadelphia area, including 1,000 Medicare eligibles under a cost contract. The HMO plans to enroll 7,000 beneficiaries under this project and will be reimbursed at 95 percent of the adjusted average per capita cost after a 12-month developmental phase. Case management, quality assurance, and benefit package enhancement will be emphasized. Seven counties in Pennsylvania and six in New Jersey will be included. An expanded benefit package including ambulatory, diagnostic, laboratory/radiology, preventive, vision care, annual physical evaluation, skilled nursing facilities, and home care is to be offered on a capitation basis as an incentive to attract the Medicare beneficiaries.

Status: Currently, HMO of Pennsylvania has been enrolling Medicare beneficiaries under their cost contract with great success. A protocol describing the demonstration program will be submitted in Fall 1983.

Medicare Competition Demonstration

Project No.: 500-82-0034
Period: September 1982 - September 1987
Contractor: Metropolitan Health Council
Indianapolis, Ind.
Project Officer: Shelagh Smith
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in Indianapolis. The demonstration will be conducted by a federally qualified, staff model health maintenance organization (HMO) with an enrollment of 33,000 members, including 500 Medicare beneficiaries enrolled under a cost contract. Under the study, the HMO will be using one large teaching hospital exclusively for its Medicare enrollees and will implement a risk-sharing arrangement with the hospital under which the hospital will receive a flat percentage of the adjusted average per capita cost (AAPCC). The Metro Health Plan (MHP) wants to test the cost effectiveness of competing for Medicare beneficiaries' enrollment in their plan based on offering an expanded package of benefits on a prospective capitation reimbursement system.

Status: MHP will start enrolling Medicare beneficiaries under this prospective capitation arrangement December 1983 and will be offering their services January 1984. Recently, the Health Care Financing Administration purchased from Electronic Data Systems Federal Corporation, the Medicaid fiscal agent, data which will provide us with the percentage of Medicare beneficiaries in institutions to determine the AAPCC. A protocol was expected in August 1983.

Medicare Competition Demonstration

Project No.: 500-82-0047
Period: September 1982 - September 1987
Funding: $ 730,959
Contractor: Health Care Network, Inc.
Oak Park, Mich.
Project Officer: Kathleen Farrell
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in Detroit. Health Care Network (HCN), owned by Blue Cross of Michigan, is a group model operating in Detroit, a competitive community. HCN is offering a "Medinet" program for Medicare beneficiaries through a network of 25 primary care physicians (PPG) composed of 8 to 25 physicians in each PPG. HCN will include measures for sharing risk for the network for referral services and hospital costs. Enrollees are required to use HCN-approved hospitals.

Status: This project is in its developmental phase. Health Care Network has submitted its draft protocol and is in the process of making revisions. The implementation date is scheduled for Fall 1983.

Medicare Competition Demonstration

Project No.: 500-82-0038
Period: September 1982 - September 1987
Contractor: Blue Cross and Blue Shield of Michigan
Detroit, Mich.
Project Officer: Kathleen Farrell
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in Detroit. A Medicare fiscal intermediary currently implementing a capitation demonstration in collaboration with Health Central in Lansing will direct this study based in Detroit, Mich. The intermediary will accept 95 percent of the adjusted average per capita cost from the Health Care Financing Administration for Medicare beneficiaries enrolled in the Detroit area. It will then contract with preferred provider organizations, starting with Detroit Medical Center, to serve beneficiaries at favorable rates.

Status: This project is in its developmental phase. The contractor is currently negotiating with the Detroit Medical Center about the terms of the demonstration, and is seeking other potential preferred providers in the Detroit area. The project is scheduled to become operational in early 1984.

Medicare Competition Demonstration

Project No.: 500-82-0039
Period: September 1982 - September 1987
Contractor: Group Health Plan of Southeast Michigan
Troy, Mich.
Project Officer: Kathleen Farrell
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in Detroit. The demonstration will involve a federally qualified, staff model health maintenance organization (HMO) that has been in operation since 1977. It serves 24,000 enrollees in the Detroit area, of which 2,000 are enrolled under a Medicaid risk contract. The HMO plans to enroll 1,000 Medicare beneficiaries a year under the demonstration to a total of 3,500.

Status: This project is in its developmental phase. The plan has submitted a draft protocol and is in the process of making revisions. The scheduled implementation date is October 1983.

Medicare Competition Demonstration

Project No.: 500-82-0040
Period: September 1982 - September 1987
Contractor: Senior Health Plan
Minneapolis, Minn.
Project Officer: John Sirmon
Division of Health Systems and Special Studies

Description: This project involves the formation and testing of a new entity, a joint venture between St. Paul-Ramsey Medical Center, Amherst H. Wilder Foundation, and Health Central, Inc. This consortium will provide comprehensive medical and institutional services to an enrolled population, and will provide benefits additional to the standard Medicare package, particularly in long-term care. Extensive use of cost sharing is proposed to control utilization.

Status: This project is in its developmental phase. An executive director has been hired for Senior Health Plan, which is the new organization being established by St. Paul-Ramsey Medical Center, Wilder Foundation, and Health Central. Other staff are being recruited. This project is scheduled to become operational in mid-1984.

Medicare Competition Demonstration

Project No.: 500-82-0041
Period: September 1982 - September 1987
Contractor: Affiliated Professionals, Inc.
Detroit, Mich.
Project Officer: John Sirmon
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in two cities. Affiliated Professionals (APRO) is a health maintenance organization (HMO) management firm headed by Mr. Robert Asmussen. APRO proposes to create a new Medicare-only HMO with enrollment at two sites--Detroit, Michigan, and Champaign, Illinois--with large teaching hospital participation. APRO will receive payments from the Health Care Financing Administration and disburse funds to the sites. A health status adjustment to the adjusted average per capita cost will be tested and utilization studied.

Status: This project is in its developmental phase. APRO is seeking investors and developing its management capability. It anticipates the demonstration project will be operational in mid-1984.

Medicare Competition Demonstration

Project No.: 500-82-0044
Period: September 1982 - September 1987
Contractor: Capital Area Community Health Plan
Latham, N.Y.
Project Officer: Nancy Row
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in the Albany area. Reimbursement will be on a prepaid per capita basis, capitated at 95 percent of the adjusted average per capita cost. Financing will be on a risk basis. Capital Area Community Health Plan is a federally qualified, staff model health maintenance organization (HMO) operating in a tri-city service area of Albany, Schenectady, and Troy, New York. The HMO has had a Medicare cost contract since 1978.

Status: This project is in its developmental phase. Capital Area submitted their draft protocol in Spring 1983, and anticipates initiating enrollment in Fall 1983.

Medicare Competition Demonstration

Project No.: 500-82-0030
Period: September 1982 - September 1987
Contractor: American Association of Foundations for Medical Care
Bethesda, Md.
Project Officer: Kathleen Farrell
Division of Health Systems and Special Studies

Description: The purpose of this Medicare competition demonstration is to develop and test alternative models of financing and/or delivering health care for Medicare beneficiaries that enhance competition. The American Association of Foundations for Medical Care, a trade association of individual practice association-model health maintenance organizations (HMO's), will conduct a demonstration involving seven of its HMO's and will test a unique component that involves the establishment of a pooled risk reserve to cover any losses of the HMO's. The number of participating plans may be expanded to 15.

Status: This project is in its developmental phase. Draft protocols have been received and are being reviewed by the Health Care Financing Administration. The project will become operational at the seven participating sites in Fall 1983.

Medicare Competition Demonstration

Project No.: 500-82-0035
Period: September 1982 - September 1987
Contractor: Health America Corporation
Nashville, Tenn.
Project Officer: G. Theodore Saffran
Division of Health Systems and Special Studies

Description: This project will demonstrate and test alternative health plans in several cities. Health America Corporation is a national health maintenance organization (HMO) management firm that owns or manages 13 HMO's. The demonstration will initially be conducted at four client sites. All sites are located in competitive areas. The participating plans are:

- HealthCare of Broward (South Florida).
- Health Service Plan of Pennsylvania (Philadelphia).

- Group Health Plan of Northeast Ohio (Cleveland).
- Rockridge Health Plan (Oakland).

Each plan will contract with the Health Care Financing Administration directly. The reimbursement will be 95 percent of the adjusted average per capita cost for the service areas involved.

Status: One of the plans, HealthCare of Broward, became operational on February 1, 1983. The design phase, including protocol, waiver approval, service agreement signature, marketing, and systems changes, was completed for an effective date of February 1, 1983. More than 1,000 Medicare beneficiaries were enrolled as a result of their transfer from a HealthCare of Broward cost contract. The HealthCare of Broward service agreement will be in effect through December 31, 1986. The other three plans are expected to become operational during 1984. A detailed protocol was expected to be completed during Summer 1983.

Medicare Competition Demonstration

Project No.: 500-82-0031
Period: September 1982 - September 1987
Contractor: MD-Individual Practice Association, Inc.
Rockville, Md.
Project Officer: John F. Meitl
Division of Health Systems and Special Studies

Description: This project will be conducted by a federally qualified, individual practice association (IPA)-model health maintenance organization (HMO) serving upper Washington, D.C., Montgomery County, and portions of Frederick, Prince Georges, and Howard Counties, Maryland, with a current enrollment of 5,000. Its primary care physicians receive an age and sex adjusted capitation fee for enrollees under their care, and have incentives to control referrals. Under this demonstration, the HMO will accept 95 percent of the adjusted average per capita cost (AAPCC) and will provide extra benefits, possibly physicals, eye exams, drugs, and dental care.

Status: MD-IPA has postponed open enrollment until May 1984. The additional months in Phase I will be used to develop new name recognition for the Plan and to conduct a market survey. The Washington, D.C., Medicaid Agency has produced the institutionalized data for the AAPCC, and the consulting firm, Birch and Davis Associates, Inc., will conduct a survey for the institutionalized data in Maryland.

Medicare Competition Demonstration

Project No.: 500-82-0048
Period: September 1982 - September 1987
Contractor: Group Health Plan of Greater St. Louis
St. Louis, Mo.
Project Officer: John F. Meitl
Division of Health Systems and Special Studies

Description: Group Health Plan of Greater St. Louis is a federally qualified, group practice model health maintenance organization (HMO) with a recent cost contract with the Health Care Financing Administration. The plan is in a designated competitive area with six other HMO's. Reimbursement under this project will be 95 percent of the adjusted average per capita cost (AAPCC). A risk pool for physicians will be established and the plan has reinsurance. Enrollment as of July 1, 1982 was 3,200 members, including 312 Medicare enrollees. The project will include a comparative evaluation of selected marketing approaches and determine if HMO membership has the potential to reduce service utilization.

Status: The Group Health Plan of Greater St. Louis will hold open enrollment in late 1983. The Missouri State Medicaid Agency has submitted institutionalized data for use in calculating the AAPCC.

Medicare Competition Demontration

Project No.: 95-P-98337/2-01
Period: June 1983 - May 1987
Grantee: Westchester Community Health Plan
White Plains, N.Y.
Project Officer: John Sirmon
Division of Health Systems and Special Studies

Description: The Westchester Community Health Plan (WCHP) is a federally qualified, staff model health maintenance organization (HMO) that has been operational since 1976 in suburban New York City. There are 115,000 residents 65 years of age or over in Westchester County, of which 800 Medicare beneficiaries have enrolled in a Section 1876 cost contract with WCHP that has been in effect since 1977. The plan currently has 20,000 enrollees. WCHP will receive 95 percent of the adjusted average per capita cost and will assume full risk for providing a comprehensive package of services.

Status: The plan has initiated development of the protocol and development of new premium rates. The plan anticipates initiating enrollment under the risk contract early in 1984.

Medicare Competition Demonstration

Project No.: 95-P-98256/2-01
Period: February 1983 - January 1987
Grantee: Genesee Valley Group Health Association
Rochester, N.Y.
Project Officer: Shelagh Smith
Division of Health Systems and Special Studies

Description: Genesee Valley Group Health Association (GVGHA) is a 10-year old federally qualified health maintenance organization (HMO) located in Rochester, N.Y. Group Health plans to compete for area beneficiaries by offering an expanded benefit package at a low premium, with a lock-in provision. The HMO will accept 95 percent

of the adjusted average per capita cost. Group Health has a cost contract with a current enrollment of 1,155, and hopes to convert most of these beneficiaries into the demonstration. Overall enrollment in GVGHA is 35,000, of which 80 percent are enrolled through commercial groups. Group Health intends to enroll 3,000 Medicare beneficiaries in the first year in four open enrollment periods lasting 2 months each.

Status: GVGHA submitted a draft operational protocol and marketing materials in June 1983. GVGHA plans to start marketing activities in September 1983, enrolling Medicare beneficiaries October 1983 and offering their services December 1983.

Medicare Competition Demonstration

Project No.: 95-P-98340/9-01
Period: June 1983 - May 1987
Grantee: French Hospital Medical Center
San Francisco, Calif.
Project Officer: Ronald Deacon
Division of Health Systems and Special Studies

Description: The purpose of the project is to test a hospital-based health maintenance organization (HMO) model designed to enhance competition in the San Francisco area and provide increased choice for Medicare beneficiaries. French will accept reimbursement at 95 percent of the adjusted average per capita cost and will offer an enriched benefit package. Projected enrollment is 6,000. The project will also study quality of care by examining severity of disease for HMO enrollees at the time of admission to acute care hospitals to determine whether the HMO's pattern of continuity of care results in less severe morbidity at admission.

Status: The project will submit an operational protocol in early 1984 which must be approved before enrollment can begin. Staff at the project are developing the protocol, marketing materials, waiver requests, and service contract.

Medicare Competition Demonstration

Project No.: 95-P-98338/0-01
Period: June 1983 - May 1987
Grantee: Group Health Service Plan d.b.a. Healthcare
Sacramento, Calif.
Project Officer: Eric R. Nevins
Division of Health Systems and Special Studies

Description: The Group Health Service Plan is a federally qualified group practice model health maintenance organization (HMO) serving 15,000 enrollees in Sacramento. The Plan has been State-certified since 1978 and curently holds a Medi-Cal contract with 5,000 enrollees. Healthcare competes with three other HMO's in the Sacramento area, two of which have Medicare cost contracts. The proposed demonstration will be similar in most respects to other Medicare competition demonstrations. Healthcare will enroll beneficiaries on a voluntary basis and will be reimbursed at 95 percent of the adjusted average per capita cost. There will be continuous open enrollment. Two

benefit packages will be offered: tentatively the low-option package will include the standard Medicare benefit package plus unlimited inpatient coverage, no 3-day requirement for skilled nursing facility coverage, vision and hearing exams, and elimination of deductibles and coinsurance. The high option package would add coverage of physical exams, immunizations, eyeglasses, hearing aids, and prescription drugs (with co-pay). Monthly premiums will be charged for both packages. Marketing methods will focus on mailings (using a list of beneficiary names and addresses supplied by the Health Care Financing Administration), newspapers, radio, and retirement group meetings. Printed information on the demonstrations will also be available at the three health centers.

Status: This project is in its developmental phase. Healthcare anticipates submitting its draft protocol in Fall 1983, with the implementation date scheduled for late 1983.

Medicare Competition Demonstration

Project No.: 95-P-98339/8-01
Period: June 1983 - May 1987
Grantee: Presbyterian/St. Luke's Health Plan
Denver, Colo.
Project Officer: Nancy Row
Division of Health Systems and Special Studies

Description: The project will test the preferred provider organization (PPO) concept for Medicare beneficiaries. The PPO will offer comprehensive Medicare benefits in Denver and seven other Colorado counties. The project will contract with the Health Care Financing Administration for 95 percent of the adjusted average per capita cost. Contracting will be on a risk basis. The plan will offer continuous open enrollment and anticipates enrolling 15,000 benficiaries by the end of 3 years.

Status: This project is in its developmental phase. Operations may begin in 6 months. An operational protocol must be submitted and approved by the Health Care Financing Adminstration before operation may begin.

Development, Implementation, and Management of Medicare Competition Demonstrations

Project No.: 500-83-0005
Period: November 1982 - May 1984
Funding: $ 143,000
Contractor: Birch and Davis Associates, Inc.
Silver Spring, Md.
Project Officer: Ronald Deacon
Division of Health Systems and Special Studies

Description: This contractor provides technical support for the Medicare competition demonstrations. Institutional surveys will be conducted to establish the adjusted average per capita costs (AAPCC) for the alternative health plans located in Arizona, Oregon, Massachusetts, and Pennsylvania, and other States where the Medicaid agencies are unable to furnish the required information. AAPCC's will be computed

using a methodology approved by HCFA's Office of Financial and Actuarial Analysis, Bureau of Data Management and Strategy, and an actuarial consultant. Essential support will continue to be provided throughout the demonstration by means of task orders.

Status: Survey forms have been mailed to all institutions in most counties where institutional data are needed. Final results of the survey were expected in Summer 1983. Birch and Davis anticipates completion of 1984 AAPCC calculations during Fall 1983.

Alternative Models for Prepaid Capitation of Health Care Services for Medicare Beneficiaries in the Twin Cities Area

Project No.:	500-78-0081
Period:	September 1978 - September 1983
Funding:	$ 902,887
Contractor:	Interstudy, Inc. Excelsior, Minn.
Project Officer:	G. Theodore Saffran Division of Health Systems and Special Studies

Description: This demonstration is testing competition among four health maintenance organizations (HMO's) for Medicare enrollees in the seven-county Twin Cities area of Minnesota. Interstudy has applied a broker concept to initially market the four plans and each HMO is being reimbursed at 95 percent of the adjusted average per capita cost, using the ratebook approach. Each HMO is competing for the target population through the use of increased benefits, reduced cost sharing, and public education.

Status: This contract had a design phase (September 1978 - September 1980) in which the operational issues and waivers were detailed. In October 1980, the four participating HMO's each signed an implementation agreement with the Health Care Financing Administration (HCFA) to be effective through December 31, 1983. As of June 1, 1983, enrollment in the demonstration reached 23,674: Share Health Plan (17,250), MedCenter (3,175), HMO Minnesota (1,983), and Nicollet/Eitel (1,266). Approximately 1,900 enrollees in Share were formerly under a HCFA cost contract. In July 1982, the Share Health Plan was granted authority to operate in an eighth county (St. Louis), approximately 200 miles northeast of the Twin Cities area. HCFA has granted a 2-year extension of the operational program through December 31, 1985. In addition, Share Health Plan and HMO Minnesota have been authorized to operate in three additional counties (Sherborne, Stearns, and Wright) beginning January 1, 1984. A fifth HMO, Group Health Plan, Inc., has been added to the Twin Cities demonstration, effective May 1983. It is anticipated that operations will begin in Fall 1983.

Alternative Models for Prepaid Capitation Financing of Health Care Services for Medicare

Project No.: 500-80-0062
Period: September 1978 - June 1983
Funding: $ 311,438
Contractor: Marshfield Medical Foundation
Marshfield, Wis.
Project Officer: Nancy Row
Division of Health Systems and Special Studies

Description: This project tested prepaid health care delivery to Medicare beneficiaries in the Marshfield, Wis., area. The project had a risk contract with the Health Care Financing Administration (HCFA) and was reimbursed on a capitated amount less than the adjusted average per capita cost (AAPCC). The benefits offered under the demonstration included all regular Medicare benefits and extra benefits ordinarily included by Marshfield in its supplementary package. Renal beneficiaries were enrolled under a separate, higher capitation rate.

Status: This project completed its operational phase in September 30, 1982, at which point nearly 9,000 beneficiaries were enrolled in the demonstration project. A draft final report has been received and is under review. Marshfield experienced major financial losses under this demonstration. During most of the demonstration, HCFA participated in a reinsurance agreement to cover losses resulting from hospital utilization in excess of that covered by the AAPCC.

Alternative Models for Prepaid Capitation of Health Care Services for Medicare Recipients

Project No.: 500-78-0082
Period: September 1978 - December 1983
Funding: $ 698,843
Contractor: Fallon Community Health Plan
Worcester, Mass.
Project Officer: Nancy Row
Division of Health Systems and Special Studies

Description: This prospective risk capitation Medicare health maintenance organization demonstration is testing a reimbursement methodology based on an adjusted community rate, with a cap established at 95 percent of the adjusted average per capita cost in its area. Savings will be returned to beneficiaries in the form of increased benefits and reduced cost sharing. A variety of marketing approaches are being tested for effectiveness.

Status: This project completed its third operational year. It will continue until December 1983 before joining the demonstration project sponsored by Blue Cross of Massachusetts. Fallon's current enrollment stands at approximately 7,000. The Plan offered its enrollees eyeglasses, prescription drugs, and low monthly premium rates. The evaluation of this project is scheduled to be completed in 1984.

Alternate Models for Prepaid Capitation of Health Care Services for Medicare Recipients

Project No.: 500-78-0078
Period: September 1978 - December 1983
Funding: $ 1,044,160
Contractor: Kaiser Foundation
Portland, Oreg.
Project Officer: Nancy Row
Division of Health Systems and Special Studies
Description: This prospective risk capitation Medicare health maintenance organization demonstration is testing a reimbursement methodology based on 95 percent of the adjusted average per capita cost in the Kaiser Portland/Oregon region. The savings between the capitation rate and the adjusted community rate will be returned to the beneficiaries in the form of increased benefits, reduced cost sharing, or both. A variety of marketing approaches are being tested.

Status: This project has had 3 years of operational experience. Enrollment currently stands at approximately 8,000. The project is scheduled to operate until December 1983. The completed evaluation of the project is expected in 1984.

Alternate Models for Prepaid Capitation of Health Care Services for Medicare Recipients

Project No.: 500-78-0079
Period: September 1978 - May 1984
Funding: $ 290,861
Contractor: Blue Cross and Blue Shield of Michigan (Health Central)
Detroit, Mich.
Project Officer: G. Theodore Saffran
Division of Health Systems and Special Studies

Description: This prospective risk capitation project is designed to test the effectiveness of a prepaid plan offering additional benefits and reduced cost sharing. The project was designed to test the ability of a newly federally qualified health maintenance organization (HMO) to enroll the Medicare and Medicaid population in Ingham, Eaton, and Clinton counties of Michigan (Lansing area). The HMO involved is Health Central, an affiliate of Blue Cross/Blue Shield of Michigan. An actuarial method is used to set the capitation amount. Thus far, the Health Care Financing Administration's payments have been less than 95 percent of the adjusted average per capita cost amounts on fee-for-service costs.

Status: The design phase was completed by October 1981 and enrollment began in November 1981. In June 1983, there were 681 Medicare enrollees. An attempt to include Medicaid in the demonstration failed when the State and the HMO could not agree upon reimbursement levels for services. Although slow in achieving their goal of 2,000 Medicare enrollees, they are continuing their efforts to provide a comprehensive benefit package for General Motors (GM) retirees in the area. GM constitutes a significant portion of the retirees in that area. Health Central will, for the first time, offer its program to GM retirees in August 1983. The project is scheduled to terminate December 1983.

Santa Barbara Health Initiative

Project No.: 11-P-98036/9-02
Period: September 1981 - December 1984
Funding: $ 424,364
Grantee: California Department of Health Services
Sacramento, Calif.
Project Officer: Eric R. Nevins
Division of Health Systems and Special Studies

Description: This research will support the Santa Barbara Health Initiative (SBHI) in the development and testing of a primary care network to serve all categories of the Medicaid population. The SBHI will be reimbursed at 95 percent of projected fee-for-service expenditures and will assume risk for Medicaid services. The primary care physicians will act as case managers, providing primary care and authorizing referrals when necessary. The SBHI will advance block payments to hospitals as an incentive to participate and be responsible for proper utilization as controlled by the primary care physician.

Status: The project is to be implemented in two phases--a developmental and an operational phase. Major deliverables submitted during the developmental phase include a provider affiliation plan, a quality assurance and evaluation plan, a risk-sharing plan, and options for reinsurance and reserve allocation. The project is planning to begin enrollment in September 1983.

Monterey County Health Initiative

Project No.: 11-P-98035/9-02
Period: September 1981 - April 1986
Funding: $ 369,490
Grantee: California Department of Health Services
Sacramento, Calif.
Project Officer: Eric R. Nevins
Division of Health Systems and Special Studies

Description: This project is designed to develop and test a capitated primary care network to serve all categories of the Medicaid population in Monterey County. The Health Initiative is organized as a case-management network focusing on the primary physician. The county will be reimbursed at 95 percent of the projected expenditures and will assume risk for Medicaid services. Primary physician accounts will be set up to monitor incoming funds and outgoing expenses. Physicians will be at risk for losses or savings that accumulate in the accounts.

Status: The project is to be implemented in two phases--a developmental and an operational phase. Major deliverables submitted during the developmental phase include a provider participation plan, a quality assurance and evaluation plan, and a plan for risk sharing. The project began enrollment in June 1983. The Monterey Health Authority has reviewed and agreed to accept 95 percent fee-for-service capitation payments from the State. Approximately 125 primary care physicians have signed contracts to participate in the project, serving 28,000 beneficiaries.

Florida Alternative Health Plan Project

Project No.: 11-P-98231/4-01
Period: June 1982 - June 1986
Funding: $ 729,114
Grantee: State of Florida
Tallahassee, Fla.
Project Officer: Ronald Deacon
Division of Health Systems and Special Studies

Description: This project is designed to demonstrate and test a number of methods for promoting competition among health care providers and insurers. The competitive models include:

- Competitive alternative health plans (competitive procurement process).
- Recipient case management (case management focused on overutilizers).
- Alternative health plan for the frail elderly (risk contracts with organizations to provide health, home, and community-based services on a prepaid basis).
- Medical care vouchers (consumer choice model utilizing non-negotiable voucher).

Status: The grantee intends to develop detailed protocols for each of the four modules which include all operational aspects of the demonstrations. Florida has developed the protocol for the competitive alternative health plans module. A request for procurement to all alternative health plans in five counties was scheduled for release in Summer 1983. Planning and development for the other three modules is occurring; however, protocols are not expected before late Fall 1983. The State is also developing a quality assurance system that will monitor potential underutilization of health services. It will be used in conjunction with all four competitive models.

Medicaid Voucher Demonstration

Project No.: 11-P-98223/5-02
Period: June 1982 - June 1986
Funding: $ 324,374
Grantee: Minnesota Department of Public Welfare
St. Paul, Minn.
Project Officer: G. Theodore Saffran
Division of Health Systems and Special Studies

Description: This project is designed to test a Medicaid capitation demonstration with the following major objectives:

- To further the evolution of a competitive health care system by shifting a publicly supported program (Medicaid) to a prepaid basis.
- To control public expenditures for health care by switching from an open-ended provider/consumer-induced demand system to a budgeted, prepaid reimbursement system.
- To create and test various policies and systems for prepaid Medicaid programs.

Status: The design phase is scheduled to be completed in June 1984, followed by a 2-year implementation. The basic accomplishment thus far in the design phase has been the hiring of the Amherst H. Wilder Foundation to be the principal management consulting firm in designing the demonstration. The design is expected to incorporate a means to convert a substantial portion of the Medicaid population in three counties (to be determined) to a prepaid, prospective risk, capitation reimbursement system. If successful, this demonstration should further intensify provider competition in the chosen counties while arresting the cost spiral in the State program. A draft protocol of the operational aspects of the demonstration is expected during Spring 1984 for Health Care Financing Administration review and comment.

Arizona Health Care Cost-Containment System

Project No.: 11-P-98239/9-01
Period: June 1982 - June 1985
Grantee: Department of Health Services
Phoenix, Ariz.
Project Officer: Sidney Trieger
Division of Health Systems and Special Studies

Description: This project is designed to test the effectiveness of establishing under the Social Security Act, Title XIX, a Medicaid program based on competitive principles, including primary care physicians acting as gatekeepers, prepaid capitated contracts, competitive bidding, the use of nominal copayments, limited restrictions on freedom of choice, and capitated payment by the Health Care Financing Administration.

Status: Arizona Health Care Cost-Containment System was implemented October 1, 1982. Completed milestones include: approval of a Section 1115 waiver application and a State plan; selection of MCAUTO systems as the contractor responsible for promotion, procurement of contract providers, provider management, public relations, and program operations; development and approval of a capitation rate; and approval of a second year continuation application. The State conducted competitive bids for the second year between June and August 1983.

Missouri Medicaid Prepaid Health Demonstration Project

Project No.:	11-P-98225/7-02
Period:	June 1982 - June 1986
Funding:	$ 393,917
Grantee:	Missouri Department of Social Services Jefferson City, Mo.
Project Officer:	Eric R. Nevins Division of Health Systems and Special Studies

Description: This project will demonstrate and test a city-wide consumer choice model characterized by the use of various incentives, marketing techniques, and the offering of a range of alternative health plans. The project incorporates components of competitive systems including:

- Consumer choice among alternative health plans.
- Risk sharing based on capitated reimbursements.
- A variety of marketing incentives.
- Participation of a range of organizational types.

All participating plans will offer the mandatory minimum benefit package for the categorically needy under the prepaid arrangement.

Status: Missouri anticipates enrolling 5,000 Medicaid recipients during the first 6 months of the demonstration, with enrollment scheduled to begin in October 1983. The operational protocol will describe the various operational aspects of the demonstration and is due 60 days before the operational period begins. The waivers are contingent on the Health Care Financing Administration's approval of the protocol.

Statewide Medicaid Competition Demonstration

Project No.:	11-P-98222/2-02
Period:	June 1982 - June 1986
Funding:	$ 792,552
Grantee:	New Jersey Department of Human Services Trenton, N.J.
Project Officer:	Eric R. Nevins Division of Health Systems and Special Studies

Description: This project will demonstrate and test a competitive model in which Medicaid eligibles may select primary care providers as case managers for 6-month intervals that will be responsible for all direct primary care delivery and referrals for ancillary services for noninstitutional recipients. Case managers will be reimbursed on a capitation principle and will be at risk for selected services. The State will contract with broker organizations selected through a bidding process that will be responsible for:

- Marketing to case managers and eligibles.
- Enrolling case managers and eligibles.
- Quality control monitoring.
- Operation of a grievance procedure system for providers and eligibles.

The Professional Standards Review Organization has been selected as the broker for the first phase.

Status: New Jersey anticipates enrolling 15,000 beneficiaries during the first year of the demonstration. The operational phase commenced in June 1983. A protocol describing the various operational aspects of the demonstration has been approved by the Health Care Financing Administration.

Monroe County MediCap Plan

Project No.:	11-P-98230/2-02
Period:	June 1982 - June 1987
Funding:	$ 700,322
Grantee:	New York Department of Social Services Albany, N.Y.
Project Officer:	Nancy Row Division of Health Systems and Special Studies

Description: Monroe County and New York State will participate in a reimbursement demonstration involving a prepaid capitated rate for Medicaid clients involved in the MediCap plan. Participating clients will be offered several delivery alternatives including existing health maintenance organizations, existing clinics or outpatient departments, or a new alternative health plan. A capitated rate, equal to or less than 95 percent of fee-for-service, will be agreed on between the State and County. The County will, in turn, develop rates for categories of eligibles with possible adjustments for types of delivery systems.

Status: This project is in its developmental phase. A final protocol is scheduled to be submitted by January 1984, with enrollment to begin June 1984. An extensive data base is being developed to construct the Medicaid capitated rate.

Competitive Managed Health Plans for AFDC Medicaid Recipients

Project No.: 11-P-98330/1-01
Period: March 1983 - March 1986
Grantee: Massachusetts Department of Public Welfare
Boston, Mass.
Project Officer: Sherrie Fried
Division of Health Systems and Special Studies

Description: This project is designed to demonstrate and evaluate four models of "managed health care," developed by the Massachusetts Medicaid program for recipients of Aid to Families with Dependent Children (AFDC), in terms of cost, utilization, consumer satisfaction, administration, and quality of care. The four models are: case management, health maintenance organizations, ambulatory capitation, and an at-risk coordinating organization.

Status: This project is in its developmental phase. The State is currently working on a protocol manual, developing the capitation rate, and negotiating with the Commonwealth Health Care Corporation, the at-risk coordinating organization.

Health Care Alternatives Within Title XIX: Evaluation of Alternative Reimbursement Methods to Providers of Primary Care Medical Services

Project No.: 11-P-98321/5
Period: April 1983 - March 1986
Funding: $ 257,925
Grantee: Michigan Department of Social Services
Lansing, Mich.
Project Officer: Gerald S. Adler
Division of Beneficiary Studies

Description: The study will examine the consequences of enrollment in innovative medical care organizations for the cost, effectiveness, quality, and accessibility of medical care provided to Medicaid populations in Michigan. The organizational types to be compared are:

- Health Maintenance Organizations (HMO's).
- Capitated Ambulatory Plans (CAP), which also are capitated but which do not cover inpatient, dental, long-term care, or personal care.
- Physician's Primary Sponsor Plan (PPSP), which features case management but in which care is paid for on a fee-for-service basis.

These organizations form a continuum of provider risk, and are to be compared with standard fee-for-service care.

Status: A sample of 20,000 Medicaid recipients in Wayne County, Michigan, has been drawn, 10,000 randomly assigned to the PPSP, and 10,000 to the comparison group. Enrollment in the PPSP program is growing more slowly than expected. Pre-enrollment studies of patient satisfaction have been conducted.

Waiver Only Competition Project for Southern California, Illinois, Indiana, and Texas

Project No.: 95-P-98342/9-01
Period: June 1983 - May 1988
Grantee: Maxicare Health Plans, Inc.
Hawthorne, Calif.
Project Officer: Shelagh Smith
Division of Health Systems and Special Studies

Description: Maxicare Health Plans, Inc. is a for-profit, federally qualified Independent Physicians' Association model health maintenance organization based in Hawthorne, California, serving five counties in Southern California as well as areas around Chicago, Illinois, Indianapolis, Indiana, and Houston, Texas. Four sites will be phased in over a 2-year period at 6-month intervals. They plan to evaluate enrollment/disenrollment, utilization, cost, and quality. The project would last 60 months and involve a total of approximately 50,000 Medicare beneficiaries (out of a total 215,000 enrollees across the four sites) enrolled in a prepaid health care program.

Status: Maxicare in Los Angeles intends to start enrolling Medicare beneficiaries under this prospective capitation in January 1984; in Illinois and Indiana, June 1984; in Texas, December 1984. A protocol is expected in Fall 1983.

Medicare Beneficiary Decisionmaking About Health Plans

Funding: Northwestern University
Center for Health Services and Policy Research
(See page 100)
Project Officer: Allen Dobson
Office of Research

Description: As part of its overall Policy Center grant to conduct health policy analyses and short-term research, Northwestern University is conducting research into what consumer behavior would be under a voucher system in which Medicare enrollees would choose among competing health plans. Their research examines consumer knowledge about health plans, interest in a voucher system, preferences regarding services covered and prices, and evidence of biased selection of high or low users into certain types of plans.

Status: Results of a survey of Medicare enrollees are being analyzed and a final report is due in Fall 1984.

Physicians' Use of Medical Care Resources in a Prepaid Group Practice Health Maintenance Organization

Project No.: 18-P-97993/9-02
Period: August 1981 - August 1983
Funding: $ 343,814
Grantee: Kaiser Foundation Research Institute
Oakland, Calif.
Project Officer: Mildred Corbin
Officer of Research

Description: This research project will measure the intensity of resource use (radiology, laboratory, drugs, outpatient procedures, and hospitalizations) by physicians in a prepaid group practice health maintenance organization, and will determine factors related to differences among physicians in the intensity of resource use. The findings will help to explain differences among physicians in patient-care patterns that affect costs of care and treatment.

Status: All data analyses are completed. The final report is being prepared.

Health Status Measure for Adjusting Health Maintenance Organization Rates of Medicare Beneficiaries

Project No.: 18-P-98179/5
Period: March 1982 - March 1984
Funding: $ 213,219
Grantee: University of Michigan
School of Public Health
Ann Arbor, Mich.
Project Officer: Marian Gornick
Division of Beneficiary Studies

Description: This study will investigate the use of a health status measure to improve the current method for reimbursing health maintenance organizations for Medicare beneficiaries under the at-risk alternative in section 1876 of the Social Security Act. The project will also explore the ability of simple measures of perceived health status obtained through telephone and mail surveys to predict future utilization and costs for a Medicare population.

Status: Field work has been completed on the survey and a response rate of 80 percent was attained. Data from Blue Cross/Blue Shield of Michigan, Michigan Medicaid, and the Medicare Statistical System (Health Care Financing Administration) are being obtained and compared with the survey data.

Adjusted Average Per Capita Costs

Funding: Brandeis University Health Policy Consortium
(See page 101)
Project Officer: James Lubitz
Division of Beneficiary Studies

Description: The University Health Policy Consortium, as part of its grant, is studying ways to improve the current adjusted average per capita cost (AAPCC). The work has been focused on three areas:

- The use of prior utilization to predict future utilization.
- The use of indicators of disability in the AAPCC.
- An examination of selected methodological aspects of the AAPCC.

Status: Prior utilization--Results indicate that prior utilization is a significant predictor of future utilization. The predictive power is improved when prior hospital stays are classified into those for self-limiting conditions and those for conditions, like cancer, indicative of chronic, recurring problems. Work is continuing to refine an AAPCC model incorporating diagnostic information on prior hospital stays. Preliminary results are contained in "Prediction of Subsequent Year Reimbursement Using the Medicare History File" by Jennifer Anderson and Abby Resnick, University Health Policy Consortium, Discussion Paper, May 1982.

Disability level--Results indicate that disability level is a significant predictor of health care use. A disability level factor, therefore, would theoretically improve the current AAPCC. However, any improvement would have to be weighed against the cost and administrative burden of acquiring disability data on Medicare enrollees. A discussion of a possible disability adjustment is contained in two draft papers from the Health Policy Consortium by Leonard Gruebnerg and Neil Stuart, "A Health Status-Based AAPCC: The Disability Level Based Approach," and "The Use of Disability Status as a Health Status Measure for Updating a Prior Utilization Reimbursement Model."

Methodological aspects--The University Health Policy Consortium has been examining a number of methodological aspects of the AAPCC. They include:

- An examination of the statistical assumptions implicit in the AAPCC.
- A synthetic estimator approach to developing a denominator for the institutional factor of the AAPCC.
- Accounting for geographic variations in the AAPCC.
- Analysis of risk sharing and reinsurance for Medicare health maintenance organizations (HMO's).
- Monitoring of HMO enrollment practices by analysis of mortality rates.

Reports on these topics should be available Fall 1983.

Research to Improve the Adjusted Average Per Capita Cost Formula to Pay Health Maintenance Organizations

Funding: Intramural
Project Director: James Lubitz
Division of Beneficiary Studies

Description: Medicare payment to at-risk health maintenance organizations (HMO's) is based on the adjusted average per capita cost (AAPCC) formula, which uses the enrollee's age, sex, welfare status, and institutional status as underwriting factors. Recent studies in the Office of Research and Demonstrations, Health Care Financing Administration, have shown that the AAPCC may not adequately adjust for biased selection of lower than average users of health services into HMO's. There has also been concern with a number of technical aspects of the AAPCC. The passage of the Tax Equity and Fiscal Responsibility Act in 1982 gave added importance to the AAPCC formula, because the new law is expected to greatly increase the number of at-risk HMO's in Medicare. The AAPCC studies examine both ways to improve the current AAPCC and the effect of adding additional underwriting factors to the formula.

Status: Current projects are investigating the use of underwriting factors based on prior use of health services, prior entitlement to Social Security disability benefits, prior entitlement to Supplemental Security Income benefits, and early retirement. The following working papers have been produced:

- o "An Examination of the Geographic Factor Used in the AAPCC."
- o "Two Studies in the Evaluation of the AAPCC: A Study of the Sensitivity of the AAPCC to the Institutional Underwriting Factors, and "Predicting Reimbursement with the AAPCC Underwriting Factors."

Former Disability as an Adjustment Factor for the Adjusted Average Per Capita Cost

Funding: Intramural
Project Director: Jerry Riley
Division of Beneficiary Studies

Description: Medicare data show that approximately 8 percent of Medicare beneficiaries 65-69 years of age were formerly entitled to Medicare because of disability. These beneficiaries tend to incur nearly twice as much reimbursement as other beneficiaries their age. Consequently, the Office of Research will develop and test an additional factor for the adjusted average per capita cost (AAPCC) that will adjust for previous receipt of Social Security disability benefits among aged enrollees. Included in the study will be beneficiaries who were formerly entitled to disability benefits under Social Security, but were never Medicare entitled.

Status: The Social Security Administration has been requested to provide information on former receipt of disability benefits for a sample of Medicare beneficiaries. It is anticipated this information will be received in September 1983. The study will also look at factors on early retirement and receipt of Supplemental Security Income benefits for possible inclusion in the AAPCC.

Use of Prior Utilization for Prospective Payment of Health Maintenance Organizations

Funding: Intramural
Project Director: James Beebe
Division of Beneficiary Studies

Description: The Tax Equity and Fiscal Responsibility Act of 1982 permits health maintenance organizations (HMO's) to receive prospective payments for their enrollees. The amount of payment is to be determined by the characteristics of the HMO's enrollees. The current adjusted average per capita cost relies on demographic characteristics of the HMO enrollees. There is considerable evidence that, even when controlling for demographic variables, HMO enrollees tend to be healthier than the general Medicare population. This research investigates the feasibility of using prior utilization along with demographic characteristics to control for this bias and more accurately predict future medical costs. The utilization variables being investigated (prior hospital days and whether or not the Part B, Supplementary Medical Insurance, deductible was met) were chosen because they are readily available from the Medicare administrative data system.

Status: The study found that for groups of persons with high or low levels of prior utilization, the models which include prior use variables predict reimbursement better than models containing only demographic variables. However, there is still room for improvement. Future work will concentrate on models that incorporate diagnosis for prior hospital stays. A working paper entitled, "Executive Summary: Using Prior Utilization Information to Determine Payments for Medicare Enrollees in HMO's" has been produced. A full report should be available in Fall 1983.

Other Alternative Payment Systems

Massachusetts Dental Case Management

Project No.: 11-P-97388/1-04
Period: February 1980 - January 1984
Grantee: Massachusetts Department of Public Welfare
Boston, Mass.
Project Officer: Shelagh Smith
Division of Health Systems and Special Studies

Description: The overall goal of this study is to demonstrate that capitated dentistry can result in a cost-effective and improved method of delivering dental care to a Medicaid population. The specific objectives are:

- To demonstrate the effects of case management and capitation on the cost and quality of dental care.
- To evaluate an alternative reimbursement method of providing dental services.

Guaranteed eligibility, capitation, and lock-in to provider (beneficiary restricted to one provider) are three concepts being tested in this demonstration.

Status: The capitated dental coverage for Medicaid beneficiaries has been implemented for 2½ years. The project reached 75 percent of its overall enrollment goals. Two thousand Aid to Families with Dependent Children recipients (670 families) have been enrolled in the experimental group. A total of only 30 people have disenrolled since the project began, mainly because they moved out of the service area. Dentists are reimbursed $4.20 per enrolled person per month, a figure that is based upon Schoen's "chair hour" formula. The formula multiplies the estimated amount of dentist and hygienist chair time by the respective costs of that time, all multiplied by estimated overall service utilization. Fourth year tasks are to complete the 2-year demonstration phase and to evaluate the demonstration. The State of Massachusetts is considering whether or not to continue the dental capitation under Medicaid at the conclusion of the demonstration period.

National Medical Care Utilization and Expenditure Survey

Analysis of NMCUES Data

Project No.: 500-81-0047
Period: September 1981 - April 1984
Funding: $ 3,487,763
Contractor: Research Triangle Park Institute
Research Triangle Park, N.C.
Project Officer: Larry S. Corder
Division of Beneficiary Studies

Description: This project involves the analysis of data (tabulations, models, and data file production) and the publication of series reports on the National Medical Care Utilization and Expenditure Survey (NMCUES). This survey was co-sponsored by the Office of Research and Demonstrations, Health Care Financing Administration, and the National Center for Health Statistics, Public Health Service. NMCUES was used to collect detailed sociodemographic, health status, health insurance, and health care payment data that were not available from either the Medicare or Medicaid administrative record systems. Data were obtained from three survey components:

- A randomly selected national household sample (HHS) of the civilian noninstitutionalized population.
- Randomly selected State Medicaid household samples (SMHS) of the civilian noninstitutionalized Medicaid population in four States: California, Michigan, Texas, and New York.
- A Medicare and Medicaid administrative records survey (ARS) linked to HHS and SMHS Medicare and Medicaid respondents.

The data collected will allow for analysis of policy issues that include the New Federalism, Medigap, out-of-pocket costs, and benefit package changes.

Status: The contract is now in its production phase. In addition to answering numerous data requests, nearly half of the 33 planned series reports are now in draft. Reports will be published during Fiscal Years 1983 and 1984. These reports will emphasize the relationship of utilization to health insurance coverage, out-of-pocket expenditures, access to health care, and Medicaid use by social and ethnic groups.

Title XIX Data Development

Acquisition and Analysis of State Medicaid Data (Tape-to-Tape)

Project No.: 500-81-0030
Period: June 1981 - April 1985
Funding: $ 1,740,366
Contractor: SysteMetrics, Inc.
Bethesda, Md.
Project Officer: David K. Baugh
Division of Beneficiary Studies

Description: This project is acquiring person-level data on Medicaid enrollment, claims, and providers from State Medicaid Management Information Systems (MMIS). Uniform files are being created to compare State trends. Data collection includes five States for 1980, 1981, and 1982. These person-level data are a key element to improve the Health Care Financing Administration's ability to conduct program evaluation, strengthen program management, evaluate policy alternatives, and assist States in the area of Medicaid financing.

Status: Through July 1983, person-level enrollment, claims, and provider files were obtained from State MMIS. System documentation was reviewed and code maps were produced to translate raw data into "uniform" files. Initial data processing and "early returns" tabulations were completed for 1980 and 1981 data from Michigan and New York. Three presentations were made to the 1982 American Public Health Association Annual Meeting, one on long-term care and the other two on use and expenditures under Medicaid.

Analysis of Information and Assistance Needs of State Medicaid Agencies

Project No.: 18-P-98220/3-01
Period: April 1983 - October 1983
Funding: $ 90,639
Grantee: American Public Welfare Association
Washington, D.C.
Project Officer: Paul W. Eggers
Division of Beneficiary Studies

Description: This project is concerned with evaluating the role and functions of the Health Care Financing Administration information and data sets and how they relate to State needs. Major emphasis will be on information related to the administration's new Medicaid program policies.

Status: This project was initiated April 1983.

Who's on Medicaid: A Comparison of Available Data

Funding: Intramural
Project Director: Gerald S. Adler
Division of Beneficiary Studies

Description: Data on Medicaid are collected from different sources for different purposes, with information on basic program parameters varying substantially. This project compares basic program statistics, such as people enrolled and served, units of services, and expenditures, from a number of sources. Data are examined from: routine administrative reports and program statistics submitted by the States to the Federal Government; a special study using Medicaid claims processing files; on-going surveys such as the Current Population Survey and the National Health Interview Survey; and one-time surveys such as the 1977 National Medical Care Expenditure Survey and the 1980 National Medical Care Utilization and Expenditure Survey. Emphasis in the analysis is on the reasons for differences.

Status: A report is being prepared. A paper will be presented at a professional meeting in Fall 1983.

Medicare Fixed-Price Contracting

Evaluation of Part B Fixed-Price Medicare Contracts

Project No.: 500-81-0041
Period: September 1981 - March 1983
Funding: $ 514,603
Contractor: Abt Associates, Inc.
Cambridge, Mass.
Project Officer: Brad Perry
Divison of Economic Analysis

Description: This project evaluates the Medicare Part B fixed-price carrier experiments in Maine, Illinois, and upstate New York. The evaluation examines the experiments' effects on program costs and quality of carrier performance. Fixed-price arrangements are compared with the previous systems in the three areas. The performance of each experimental contractor is also compared with the performance of two comparable cost-reimbursed contractors.

Status: Findings indicate that the fixed-price contractor experiments resulted in reduced Federal costs for carrier services. The decreased costs were achieved by using different processing sites and better processing systems, and through some economics of scale. With the partial exception of Illinois, no adverse impact of the experiments on beneficiaries or providers has been found.

Study of the Quality and Effectiveness of Experimental Fixed-Price Medicare Part A Intermediary Contracting

Project No.: 500-83-0030
Period: June 1983 - December 1984
Funding: $ 203,595
Contractor: Abt Associates
Cambridge, Mass.
Project Officer: William J. Sobaski
Division of Reimbursement Studies

Description: This project will examine the impact of experimental fixed-price contracting for intermediary services in two States, New York and Missouri. The contractor will assess the procurement processes, the transition periods, and the resultant states of readiness for operations. Analyses will be made of claims processing and program outlays, provider and beneficiary services, and the quality of audit and settlement services in the initial year of operations on a fixed-price basis. Recommendations will be provided for a methodology suitable for use in evaluating other fixed-price contracting arrangements.

Status: This project was initiated June 27, 1983. Site visits will begin in September 1983. Initial descriptive and analytic reports flow will start in December 1983 and continue on a bimonthly basis.

Program Management

Methodology for Performing Computer-Assisted Simulations of the Effects of Changes in Medical Procedural Terminology Systems

Project No.: 500-78-0013
Period: June 1978 - April 1984
Funding: $ 1,047,631
Contractor: Moshman Associates
Bethesda, Md.
Project Officer: William Sobaski
Division of Reimbursement Studies

Description: This project studies physician response to reimbursement alternatives including analysis of price trends, relative values, and relations between medicine and private health insurance. An objective of the project is to develop and demonstrate a methodology for simulating the effects of changes in medical procedural terminology and coding systems on program outlays, statistics, information systems, and reimbursement levels.

Status: The project to date has:

- Developed California Relative Value Studies, National Association of Blue Shield Plans, and Current Procedural Terminology (CPT) crossovers to the Health Care Financing Administration Common Procedural Coding System (HCPCS).

- Developed Current Procedural Terminology-4, 3rd Revision to International Classification of Diseases, 9th Revision, Clinical Modification, Volume 3 crossovers.

- Developed a computerized monitoring system and discussed it at a conference of 200 carriers, State, and Health Care Financing Administration representatives.

- Assessed first 2 years of HCPCS usage in South Carolina.

- Asessed first 2 months of HCPCS usage in Washington.

Proposal for the Development of a Medicaid Fraud and Abuse Detection Methodology

Project No.: 11-P-97617/5-02
Period: March 1980 - March 1983
Funding: $ 57,832
Contractor: Illinois Department of Public Aid
Springfield, Ill.
Project Officer: Rose M. Truax
Division of Hospital Experimentation

Description: This 3-year project will develop and field test an empirically-based fraud and abuse detection methodology for the Illinois Medicaid Program to increase the State's review and monitoring capabilities. The basic assumption is the belief that various types of fraud and abuse practiced by Title XIX providers represent conscious decisions regarding trade-offs between:

- Exposure to risk and desired per-unit profit.

- Desired level of effort.

- How those factors relate to a target level of profit associated with practice size.

Status: The grantee examined the data available on providers who were audited between 1973 and 1979. Profiles were developed as a result of the data analysis. A final report is due Fall 1983.

State Medicaid Information Center Project

Project No.: 18-P-97923/3-03
Period: January 1981 - January 1985
Funding: $ 719,018
Contractor: National Governors' Association
Washington, D.C.
Project Officer: Aileen Pagan-Berlucchi
Division of Beneficiary Studies

Description: This grant project monitors changes in State Medicaid program policy and disseminates information on these changes through a survey-based report updated every 6 months. The National Governors' Association (NGA) also contracts with research groups outside the Federal Government to produce research reports on special topics of current interest in the area. The project group at NGA works closely with State Medicaid Directors and other program personnel in developing research topics and data collection priorities.

Status: Key products from this project include:

- Medicaid Survey Report: "Recent and Proposed Changes in State Medicaid Programs" from 1982 on, co-published with the Intergovernmental Health Policy Project.
- "Primary Care Network and Medicaid" - A background paper, December 1981.
- "Medicaid: Freedom of Choice" - A review of waiver applications submitted under Section 2175 of the Omnibus Budget Reconciliation Act of 1981, August 1982.
- "Volume Purchasing of Goods and Services in State Medicaid Programs," October 1982.
- "Medicaid Program Changes, State-by-State Profiles," May 1982.
- "Controlling Medicaid Costs: Second Surgical Opinion Programs," November 1982.
- "Catalog of State Medicaid Program Changes - The State Medicaid Program Information Center," December 1982.
- "Reducing Excessive Utilization of Medicaid Services: Recipient Lock-in Programs," June 1983.
- "Nursing Homes, Hospitals and Medicaid: Reimbursement Policy Adjustments, 1981-1982," March 1983.

Intergovernmental Health Policy Project

Project No.: 18-P-98148/3-02
Period: March 1982 - February 1985
Funding: $ 885,000
Grantee: George Washington University
Washington, D.C. 20052
Project Officer: Aileen Pagan-Berlucchi
Division of Beneficiary Studies

Description: This grant project describes current health law, policy and legislative actions affecting State Medicaid programs. The Intergovernmental Health Policy Project (IHPP) compiles and disseminates information on State health activites, including new developments in the Medicaid cost-containment area. IHPP serves as a clearinghouse on State legislative actions. Through this clearinghouse function, IHPP distributes a monthly newsletter, "State Health Notes," detailing the current status and pending changes in the medical program. IHPP also disseminates special summaries of topical issues in the Medicaid program through the "Legislative Snapshot" report series and periodic background reports.

Status: Key products from this project include:

- Medicaid Survey Report: "Recent and Proposed Changes in State Medicaid Programs" from 1982 on, co-published with the National Governors' Association.
- "State Health Notes," a newsletter published 10 times each year.
- Background reports (for example, "Medigap: Issues and Update, 1982," and "Alternatives to Institutional Care for the Elderly: An Analysis of State Initiatives," September 1981)
- "Legislative Snapshot" (on such topics as nursing homes and Medicaid)
- "State Mental Health Notes," a newsletter published 10 times each year.

Reporting

Assessment and Redesign of Health Maintenance Organization (HMO) Reporting Requirements Project

Project No.: 18-P-97559/3-02
Period: March 1980 - March 1983
Funding: $ 311,460
Contractor: Group Health Association of America
Washington, D.C.
Project Officer: Nancy Row
Division of Health Systems and Special Studies

Description: The objective of this project was to develop a health maintenance organization (HMO) reporting system that can be used by Federal and State agencies and HMO's to avoid unnecessary duplication and attendant costs.

Status: A final report has been received. A document that represents an untested version of a consolidated HMO reporting format to service multiple data users has been prepared. The format builds on integrated core reports that provide summary data on enrollment, utilization, and a variety of financial information.

Policy Centers

Program in Health Care Policy and Financing at Northwestern University

Project No.: 18-P-97265/5-04
Period: September 1978 - March 1983
Funding: $ 2,334,008
Grantee: Northwestern University
Evanston, Ill.
Project Officer: Allen Dobson
Office of Research

Description: The Center for Health Services and Policy Research of Northwestern University assists the Health Care Financing Administration (HCFA) in evaluating and conducting health policy analyses and short-term research projects in priority areas affecting programs that are administered by HCFA. Each year under the 5-year grant, the Center and HCFA develop an agenda of specific topics and projects to conduct. The Center then submits the research and policy papers to HCFA as the studies are completed. They also publish their findings in professional journals.

Status: This policy center is in its fifth and final year of operation. Six studies are being conducted:

- Routine Care of the Foot: Implications of Medicare Exclusion.
- Freestanding Ambulatory Health Centers.
- Cost-Effectiveness of Preventive Health Care for HCFA Beneficiaries.
- Medicare Beneficiary Decisionmaking About Health Plans.
- Lessons from the Experience of State Catastrophic Health Insurance Programs.
- Trends in Medicaid Program Expenditures and Changes in Medicaid Program Characteristics.

Final reports on these projects are expected during 1983.

Health Care Financing and Regulation Center at Brandeis University Health Policy Consortium

Project No.: 18-P-97038/1-05
Period: May 1978 - May 1983
Funding: $ 3,683,350
Grantee: Brandeis University
Waltham, Mass.
Project Officer: Allen Dobson
Office of Research

Description: The University Health Policy Consortium assists the Health Care Financing Administration (HCFA) in evaluating and conducting health policy analyses and short-term research projects, concentrating in the areas of long-term care, health care quality and effectiveness, and regulation and reimbursement. Each year under the 5-year grant, the Consortium and HCFA develop an agenda of specific topics and projects to conduct. The Consortium then submits the research and policy papers to HCFA as the studies are completed. They also publish their findings in professional journals.

Status: This policy center is in its fifth and final year of operation. There are twelve current projects underway. Of these, five projects were continued from the fourth year of funding:

- Kidney Procurement in the United States.
- Case-Mix Differences Between End-Stage Renal Disease Facilities.
- Home Health Cost Functions.
- Urban Hospital Closing: Qualitative Analysis.
- Mandatory Home Health Studies.

Four projects were related to efforts to improve program efficiency:

- Effect of Medicare Policy on Clinical Policy and Utilization.
- Medicare Cost Control through Claims Analysis.
- Pediatric Appropriateness Evaluation Protocol Instrument.
- Technology Assessment for Insurance Coverage Decisions.

Three projects were related to issues in competition:

- Adjusted Average Per Capita Costs.
- Vertical Integration of Hospitals and Long-Term Care.
- Competition in Home Health.

One project is related to the issues associated with the New Federalism for Medicaid. In addition, a special report, "Alternative Reimbursement for Home Health Services under Medicare" was prepared to provide a resource document for the preparation of a Report to Congress. The report was mandated by the Orphan Drug Act (Public Law 97-414). The Act requires the Secretary of the Department of Health and Human Services to compile and analyze the results of significant studies relating to current and alternative methods of reimbursing for home health services and to make recommendations on methods that might be adapted to federally funded health care programs. The Brandeis study will be made available to the public following the submittal of the report to Congress in Fall 1983.

Program Analysis

An Evaluation of Equity Under the Medicare Program

Project No.:	18-P-97874/2-02
Period:	July 1981 - June 1983
Funding:	$ 319,908
Grantee:	Syracuse University Health Studies Program Syracuse, N.Y.
Project Officer:	John Petrie Division of Reimbursement Studies

Description: There are two objectives to this project:

- To reexamine the various concepts of equal access to care and to develop the econometric models suitable for measuring these concepts.
- To confirm previous research findings that Medicare has made substantial gains toward providing equal access to care and that Medicare cost-sharing provisions lead to significantly lower levels of hospital and physician utilization.

It is important that methodological advances be made and tested on the 1977 Current Medicare Survey so that when data from the new Health Care Financing Administration survey of beneficiaries (National Medical Care Utilization and Expenditure Survey) become available, appropriate tools also are available for analysis, and an historical baseline exists with which the new data may be compared.

Status: Four reports have been submitted:

- "Equity and Medicare: Evidence for Vulnerable Elderly Subpopulations."
- "Who Bears the Burden of Medicare Cost-Sharing?"
- "Medicare Cost-Sharing and Private Supplementary Health Insurance: Selected Research Findings."

- "Cost-Sharing, Supplementary Insurance, and Health Service Utilization Among the Medicare Elderly: Revised Estimates."

Findings from these reports include:

- Those elderly Medicare beneficiaries who also were covered under the Medicaid program used 25 percent more hospital days than those beneficiaries who had no supplemental health insurance and those beneficiaries who had private supplementation. This same increase in utilization held true for physician visits.

- The likelihood of acquiring private supplementation initially rises sharply as family income rises to about $10,000; further increases in income have no effect on the private supplementation rate.

- The most striking inequities in Medicare cost-sharing burdens occur at the lowest income levels, i.e., between $2,600 and $3,250. In addition, black people are about twice as likely as white people to have to meet the full cost-sharing burden out of pocket.

A last report investigating the conditions for the elderly subgroups that prevailed just before Medicare was passed is being written and is expected by December 1983.

Medicaid Programmatic Characteristics Research Study

Project No.:	500-81-0040
Period:	September 1981 - September 1983
Funding:	$ 472,320
Contractor:	La Jolla Management Corp. Rockville, Md.
Project Officer:	Donald N. Muse Division of Medicaid Cost Estimates Bureau of Data Management and Strategy

Description: This study will design and implement a data system that will, on a selected basis, unify State Medicaid program characteristics, such as eligibility requirements, service limitations, routine statistical report data, and administrative details, in a single source. This data base will be updated periodically for the Health Care Financing Administration (HCFA).

Status: The study has produced, on schedule, a report detailing the first year's characteristics data. A tape containing this data has also been delivered to HCFA. By its conclusion, the study will produce a second year's data tape as well as procedures for HCFA to update the data on an annual basis.

Medicaid Cost Containment and Urban Medical Care

Project No.: 18-P-97728/3-02
Period: June 1980 - June 1983
Funding: $ 704,737
Grantee: The Urban Institute
Washington, D.C.
Project Officer: Paul Eggers
Division of Beneficiary Studies

Description: The primary objective of this study is to analyze the impact of changes in Medicaid policies on local governments' spending for medical care and hospitals' financial status. The impact on local governments' spending is based on time-series, cross-section data for 22 large cities (in 15 states) over an 11-year period, 1968-1978. Histories of each jurisdiction's Medicaid policies and policy changes are being compiled.

Status: The analysis of hospitals' financial status will be based on a survey of all hospitals with 100 beds or more in the 199 largest cities. The survey will obtain information on charity care, bad debts, and contractual allowances, as well as the distribution of hospitals' revenues by source. These data will be subjected to statistical analyses to identify the effects of interstate variations in Medicaid policies. The final report is expected in Fall 1983.

Trends in Medicaid Program Expenditures and Changes in Medicaid Program Characteristics

Funding: Northwestern University Center for Health Services and Policy Research
(See page 101)
Project Officer: Paul W. Eggers
Division of Beneficiary Studies

Description: This project examines Medicaid program data for 1973-82 to determine the State variations that have occurred in program expenditures. Analyses examine expenditures by type of service and by eligibility group. Changes in expenditures are compared to changes in program administration and coverage to determine the effect that State policies have had on the Medicaid program.

Status: The project was begun March 1983. A final report is due March 1984.

Use of Medicare Services by Disabled Enrollees Under 65 Years of Age

Funding: Intramural
Project Directors: James Lubitz and Penny Pine
Division of Beneficiary Studies

Description: More research has been devoted to the Medicare aged population than to the population of disabled enrollees under 65 years of age. Yet disabled enrollees comprise about 10 percent of Medicare enrollment, and Medicare expenditures for them have been rising faster than for aged enrollees. To increase available knowledge of the Medicare disabled population, analyses are being carried out on patterns of health services used by the disabled. In particular, this population is being analyzed by type of disability award, i.e., disabled worker, adult disabled in childhood (ADC), or disabled

spouse. Also, the aged (over 65 years of age) Medicare population who were formerly disabled Medicare beneficiaries are being studied.

Status: Early results indicate that per capita reimbursement for the disabled are equal to that of the aged and that disabled women exceed men in per capita reimbursement. The majority (82 percent) of the Medicare disabled population are disabled workers, 14 percent are adults disabled in childhood (ADC), and 4 percent are disabled spouses. Per capita reimbursement in 1978 for the ADC was considerably lower ($345) than for the disabled worker ($924) or the disabled spouse ($1026). Aged Medicare beneficiaries who were formerly disabled Medicare beneficiaries have 1.8 times the per capita reimbursement of other Medicare beneficiaries in the same age group. A second study is being planned linking the Social Security Administration's Disability History File to Medicare records. When the link is completed, analyses will examine such factors as the relationship of reason for disability, length of time disabled, and return to work to health care use.

Use of Services by the Dually Entitled

Funding: Intramural
Project Director: James Lubitz
Division of Beneficiary Studies

Description: More than 13 percent of the aged population are covered by both Medicare and Medicaid. In view of the proposed and recently enacted changes in both programs, the health care use of the dually entitled is of special interest.

Status: A recently completed study of Medicare use by the dually entitled, published in the Summer 1983 issue of the Health Care Financing Review, found that per capita Medicare reimbursement for the dually entitled was 50 percent higher than for other enrollees. The mortality rate was also 50 percent higher for the dually entitled. The study also found that the relative mortality rate of the dually entitled, compared with other Medicare enrollees, was highest in the youngest age group. In the group 65-69 years of age, the death rate for the dually entitled was 80 percent higher than for other enrollees; in the group 85 years of age and over, the rate was 30 percent higher. Two further studies are in progress on the dually entitled. The first uses the National Medical Care Utilization and Expenditure Survey to examine utilization and reimbursements made by Medicare, Medicaid, and other sources, and the relation of health status, education, and income to health service use. This study is confined to noninstitutionalized persons. The second study includes institutionalized and noninstitutionalized enrollees and uses person-level data from Medicare and Medicaid in selected States. It will focus on patterns of long-term care and hospital use by the dually entitled.

Impact of Deductibles and Coinsurance on Medicare Enrollees

Funding: Intramural
Project Officer: Marian Gornick
Division of Beneficiary Studies

Description: More than half of Medicare enrollees purchase private supplemental policies ("Medigap") to protect against the costs of Medicare deductibles and

coinsurance. This study examines the distribution of liabilities for Medicare cost-sharing and offers proposals for restructuring Medicare coverage to both reduce the need to purchase Medigap coverage and to better protect against catastrophic cost-sharing liabilities.

Status: A report of this study is scheduled for publication in the Fall 1983 issue of the Health Care Financing Review. In 1980, 25 percent of Medicare enrollees had Medicare cost-sharing liabilities of $200 or more. The cost of protecting enrollees against liabilities in excess of $200 would have been $86 per enrollee in 1980. A model was developed to estimate the additional cost in 1984 of fixing liability at selected limits. The added cost of the protection would be offset by reduced need to purchase "Medigap" policies. Alternatively, Medigap policies offering such catastrophic protection could be offered at lower premiums than present policies offering first-dollar insurance against coinsurance and deductibles.

Studies of Medicare Use Before Death

Contact: James Lubitz
Division of Beneficiary Studies

Description: These studies examine the use of Medicare services in the last years of life. This information is needed because of the large percentage of Medicare expenditures for enrollees in their last year and because of the interest in hospice care as an alternative kind of care for the terminally ill.

Status: Studies have shown that 28 percent of Medicare expenditures are for persons in their last year, that persons who die receive more than six times the reimbursements of other enrollees, and that expenditures in the last year are concentrated in the last few months. The results of these studies are scheduled for publication in Health, United States, 1983, the annual report from the Secretary of the Department of Health and Human Services to the President and Congress. Knowledge gained in these studies is being applied in the administration and evaluation of the hospice benefit. Work is underway to compute the legislatively mandated limit (cap) on reimbursements to hospices. In addition, data on Medicare reimbursements for the dying in conventional settings will be used as comparison data to evaluate the cost and utilization experience under the new hospice benefit. Finally, to expand the range of uses of data on use of Medicare benefits before death, a contract has been awarded to obtain permission from States to access their death certificate information at the National Center for Health Statistics. When the contract is completed, Medicare use will be analyzed by cause of death.

Post-Surgical Mortality Among the Aged for Common Operations

Funding: Intramural
Project Officer: Jerry Riley
Division of Beneficiary Studies

Description: About 2.5 million hospital stays for surgery for Medicare enrollees occur annually. Much of this surgery is to some extent discretionary. Thus, to the extent that some of these surgical procedures could be avoided, some of the associated mortality might be reduced. This study examines mortality up to a year after five common operations--cholecystectomy, prostatectomy, inguinal hernia repair, cataract

removal, and hip repair--comprising about one-quarter of operations for Medicare enrollees. The study will also determine whether an association exists between mortality rates and annual volume of operations performed at individual hospitals.

Status: Preliminary results for 1977-78 show that the risk of dying markedly increases with age and that patients operated on for prostatectomy and hip repair have higher than average mortality for up to a year following the operation. Preliminary results also show lower post-surgical mortality in the West for all five operations. Further analyses will cover the years 1979-81, and will include several other operations. Additional patient and hospital characteristics will also be examined.

Study of High Cost Infants Under Medicaid

Funding: Intramural
Project Director: Jerry Riley
Division of Beneficiary Studies

Description: This study will focus on infants who incur high levels of reimbursements under the Medicaid program. Michigan data for 1980 and 1981 from the Health Care Financing Administration's "Tape-to-Tape" project will be used, with more States to be added if data become available in time. The study will focus on costs, diagnoses, services, incidence (in Medicaid), and mortality rate for such infants.

Status: This study was recently initiated. Preliminary data indicate that in 1981 there were about 500 hospitalizations for premature birth in Michigan, with average hospital costs of about $11,000.

Changes in the Distribution of Medicare Expenditures

Funding: Intramural
Project Director: Jerry Riley
Division of Beneficiary Studies

Description: A large portion of Medicare expenditures has historically been concentrated on a small number of beneficiaries who are heavy users of services. The question often arises as to whether expenditures under the program have become more or less concentrated over time among small numbers of high-cost individuals. This study will compare distributions of Medicare reimbursements for 1969, 1975, and 1981. Michigan Medicaid expenditures for 1981 will also be examined.

Status: Preliminary data indicate that Medicare reimbursements may have become slightly less concentrated in recent years. A working paper will be developed by November 1983.

Medicare/Medicaid Data Book

Funding: Intramural
Project Director: Aileen Pagan-Berlucchi
Division of Beneficiary Studies

Description: This report provides descriptive statistics on the organization and operation of the Medicare and Medicaid programs. It features cross-program comparisons on recent trends in program recipients, expenditures, and service utilization as well as in-depth discussions of the basic operating principles of each program. Several appendixes are also included that detail relevant studies on selected issues in each program, sources of information contained in the book, and the names and addresses of program officials at the Federal and State levels. This report is intended as a resource tool for public officials, researchers, policy analysts, and health care consumers and providers.

Status: The Medicare and Medicaid Data Book, 1981 was the first edition of this report, and it is available upon request from: Office of Research and Demonstrations, Publications Staff, Rm. 2-E-6, Oak Meadows Building, 6325 Security Boulevard, Baltimore, Md. 21207. The 1983 edition is in production (no 1982 edition).

Program Statistics Series Reports

Funding: Intramural
Project Director: Herbert Silverman
Division of Beneficiary Studies

Description: Based on administrative files and bills submitted for Medicare-covered services for program beneficiaries, statistical reports are issued on a regular basis that provide data on the number and characteristics of program beneficiaries; the number, distribution, and characteristics of providers certified to furnish services to Medicare enrollees; and the patterns of use of program benefits by beneficiaries. Use of benefits is examined by the characteristics of the persons using them, the providers furnishing the services, and the distribution of charges and reimbursements to beneficiaries and providers. The purpose of these reports is to show trends and to examine the factors that may be influencing those trends.

Status: The following reports are in the process of being published or have been sufficiently developed that usable data are available:

- "Medicare: Use of Short-Stay Hospitals by Aged and Disabled Inpatients, 1978"
- "Medicare: Use of Physicians' Services under the Supplementary Medical Insurance Program, 1975-1978"
- "Medicare: Participating Health Facilities, 1974-1979"
- "Medicare Summary: Use and Reimbursement by Person, 1979"
- "Medicare: Health Insurance for the Aged and Disabled, Reimbursement by State and County, 1980"
- "Medicare: Persons Enrolled in the Health Insurance Program, 1980"
- "Medicare: Use of Skilled Nursing Facility Services, 1979"

- "Medicare: Use of Hospital Outpatient Services, 1979"
- "Medicare: Use of Home Health Services, 1980"

The following reports are under development:

- "Medicare: Use of Hospital Outpatient Services, 1981"
- "Medicare: Use of Short-Stay Hospitals by Aged and Disabled Inpatients, 1980"

Program Evaluation

State Mortality Statistics

Project No.: RFC-83-P569
Period: June 1983 - February 1984
Funding: $ 236,310
Contractor: Association for Vital Records and Health Statistics
Portland, Oreg.
Project Officer: James Lubitz
Division of Beneficiary Studies

Description: The purpose of the contract is to obtain permission from States to use their death certificate data directly from the National Center for Health Statistics (NCHS). Once these authorizations have been given, mortality data for 1979, including cause of death, will be linked to Medicare records for a sample of 65,000 Medicare enrollees through a direct computer match. The contract represents a major advance in the efficient use of vital records. Researchers normally must request records from each State and then must code and enter information from hard-copy records. The resulting data file will be used for studies on the relationship of use and costs of Medicare services to cause of death. The data will be used as comparison data in the evaluation of the Medicare hospice benefit.

Status: Permission from 31 States for a direct computer link of NCHS mortality data to Medicare records has been received.

Time Series Variation Rate Study of Medical Care Problem Areas Identified and Affected by PSRO MCE Studies

Project No.: 500-78-0050
Period: September 1978 - June 1983
Funding: $ 703,110
Contractor: Corbin Associates, Inc.
McLean, Va.
Project Officer: Gerald S. Adler
Division of Beneficiary Studies

Description: As part of the Health Care Financing Administration's evaluation of the Professional Standards Review Organizations (PSRO) program, this study assessed the effects of the Medical Care Evaluation (MCE) studies conducted under PSRO auspices. MCE's were conceived as the mechanism, based on the medical audit method, by which

PSRO's assured that quality of care was maintained and improved. The study assessed adherence to objective standards of care before and after MCE's were done to see whether changes in compliance could be detected. It also estimated the benefits and costs associated with MCE's and the factors which facilitated or hindered PSRO quality assurance programs.

Status: The interim report of this project, which is contained in the 1979 Departmental evaluation of the PSRO program, showed that quality assurance had increased compliance with standards. No direct relationships were found between the improvements and such variables as hospital size, location, ownership, teaching affiliation, or MCE delegation status. This is one of the few large-scale quality of care evaluations. The summary volume of the final report has been received and will be made available through the National Technical Information Service.

Medicaid Short-Term Evaluation

Project No.: 100-82-0038, Task Order 5
Period: March 1983 - November 1983
Funding: $ 125,000
Contractor: Urban Systems Research and Engineering, Inc.
Cambridge, Mass.
Project Officer: Gerald S. Adler
Division of Beneficiary Studies

Description: This is the second in a series of evaluative studies focusing on the effects of the Omnibus Budget Reconciliation Act of 1981 and subsequent legislation on the Medicaid program. The first study prepared the groundwork by specifying evaluation issues, data, and methods. The current study uses available data to address these policy issues, focusing particularly on eligibility changes, utilization by the institutionalized and dually eligible groups, and distributional analyses of utilization.

Status: Data analysis has begun.

State Legislative Resource and Information Center on Health Care Financing

Project No.: 19-P-98266/8-01
Period: June 1983 - May 1986
Funding: $ 547,017
Grantee: National Conference of State Legislatures
Denver, Colo.
Project Officer: Vic McVicker
Division of Hospital Experimentation

Description: This project will demonstrate that a centralized source of information on State and Federal health care financing initiatives and programs will assist the Nation's State legislatures, as well as the Health Care Financing Administration, by contributing to a more informed decisionmaking process. A number of mechanisms will be used to establish and disseminate information from the resource center. These include surveys of State legislatures, publications, seminars, direct technical assistance, and response to requests for specific information.

Status: This new grant is a continuation of similar efforts of a previous project which terminated on May 31, 1983.

End-Stage Renal Disease

National Kidney Dialysis and Kidney Transplantation Study

Project No.: 95-P-97887/0-02
Period: January 1981 - January 1984
Funding: $ 776,750
Grantee: Battelle Memorial Institute
Seattle, Wash.
Project Officer: Carl Josephson
Office of Research

Description: The purpose of this study is to analyze the impact of alternative types of therapy on end-stage renal disease (ESRD) patients. Patient outcomes are measured in terms of the patient's quality of life, quality of care, cost of care, and rehabilitation status. Data collection instruments included direct patient interviews, facility-based medical records abstracts, completion of patient medical expense diaries, and the Health Care Financing Administration program data records from entitlement forms, provider certification records, facility survey files, facility cost reports, facility and provider reimbursement records, and other medical information files.

Status: Data based on 850 ESRD patients receiving care under four different types of therapy from 11 renal dialysis centers and facilities were collected during the first 18 months of the study. The next 12 months were spent in the editing and analysis of the basic data and the preparation and publication of 19 supporting documents and 11 major papers. In general, the study found that patients are not randomly assigned to different treatment modalities and that case-mix differences do affect patient outcomes. There were significant differences in the measures of quality of care and quality of life by type of therapy, and these differences persisted after adjusting for differences in patient case mix. Also, significant declines in labor force participation were associated with onset of the renal disease. In the study, only about one-half of the patients used rehabilitation services, and their use of services varied significantly across types of treatment modalities. Among the patients in the study for whom peritoneal dialysis is most appropriate, the choice of continuous cycling peritoneal dialysis represents an inceasingly attractive alternative to continuous ambulatory peritoneal dialysis or intermittent peritoneal dialysis, since the patients were found to have a lower incidence of peritonitis, fewer hospital admissions, and fewer days hospitalization. Both short- and long-term complications are associated with organ transplantation. Serious complications are more likely to be present among ESRD patients who have experienced a failed transplant than among patients who have successfully functioning allografts. These differences, however, are not attributable to patient case-mix differences since the two patient transplant groups do not differ with regard to age, sex, race, education, and primary disease diagnosis.

The major papers were:

- "Case Mix, Treatment Modalities, and Patient Outcomes: Results of the National Kidney Dialysis and Kidney Transplantation Study."
- "A Comparative Assessment of the Quality of Life of Patients on Four Treatment Modalities."
- "Functional Impairment, Work Disability, and the Availability and Use of Rehabilitation Services by Patients with Chronic Renal Failure."
- "Labor Force Participation Among ESRD Patients."
- "Health Services Utilization and Disability Days: Indicators of the Quality of Patient Care Among ESRD Patients."
- "Premorbid and Post-Treatment Functional Limitations Among Patients with Chronic Renal Failure."
- "Complexities in the Treatment of ESRD: Economic Efficiency and Treatment Modality Prescription."
- "The Demographic Characteristics of the National Kidney Dialysis and Kidney Transplantation Study: A Comparison With the ESRD Population."
- "The Use of Rehabilitation Services by Patients With Chronic Renal Failure."
- "Peritonitis, Hospital Admissions, and Days Hospitalized Among Patients on CAPD and CCPD: A Comparative Assessment."
- "Extrarenal Complications Among Kidney Transplantation Recipients."

The final year of the study will be devoted to the analysis and preparation of additional analytical papers.

Encouraging Cost-Effective Treatment of End-Stage Renal Disease

Project No.:	18-P-97585/5-03
Period:	March 1980 - March 1983
Funding:	$ 203,473
Grantee:	Indiana University Foundation School of Medicine Indianapolis, Ind.
Project Officer:	Paul Eggers Division of Beneficiary Studies

Description: This project was initiated to develop knowledge on the basic nature and cost of treatment alternatives for end-stage renal disease, and to examine the effects of the changes to the current system by using a computer simulation model to compute cost effectiveness.

Status: Working papers resulting from the project are:

- "Characteristics of the Health Care Financing Administration (HCFA) Home Hemodialysis Patients' Data," July 1982.
- "Descriptive Characteristics of HCFA Renal Transplant Data," May 1982.
- "Outcome Characteristics of HCFA Renal Transplant Data," May 1982.

The final report was received in June 1983.

Physicians Who Care for End-Stage Renal Disease Patients: A National Study of Their Practices, Patients, and Patient Care

Project No.: 18-P-98174/9
Period: March 1982 - July 1983
Funding: $ 308,978
Grantee: University of Southern California
Los Angeles, Calif.
Project Officer: Benson Dutton
Division of Reimbursement Studies

Description: This project involved the design and conduct of a national physician-oriented study of the time and effort allocated to various professional activities and patient-care services. The target population included all physicians who render care to patients with end-stage renal disease (ESRD) and who participate in the program under the alternative reimbursement method. Such physicians represent more than 75 percent of the physicians who treat ESRD patients. The study is all inclusive in the sense that the physicians surveyed were asked to report on their entire practice and the full array of their professional activities.

Status: The physician survey, which began in October 1982, achieved a final response rate of 63.2 percent. A progress report detailing the survey efforts was submitted in January 1983. The grantee has also submitted draft data documentation specifications for data tapes to be produced.

Evaluation of Reimbursing Home Dialysis Aide Demonstration

Project No.: 500-79-0054
Period: September 1979 - January 1983
Funding: $ 990,037
Contractor: Orkand Corporation
Silver Spring, Md.
Project Officer: Spike Duzor
Evaluative Studies Staff

Description: This study was initiated to evaluate the effectiveness of three demonstrations designed to increase the efficiency of the end-stage renal disease (ESRD) program without reducing the quality of care to ESRD patients. The study was

to determine whether patients dialyzing at home assisted by paid aides is less costly than outpatient facility dialysis.

Status: A final report was accepted in June 1983. Findings indicate that home dialysis with an aide is an effective method for reducing ESRD program costs.

Design of a Demonstration and Assessment of Competitive Health Insurance Proposals in the End-Stage Renal Disease Program

Project No.: 14-P-98275/3-01
Period: April 1983 - March 1985
Funding: $ 380,532
Grantee: The Urban Institute
Washington, D.C.
Project Officer: Mel Bulkley
Division of Health Systems and Special Studies

Description: This project will determine the feasibility of demonstrations to test competitive financing approaches in the end-stage renal disease program, with possibilities including:

- Competitive bidding.
- Global capitation covering all medical care costs.
- Partial capitation covering only outpatient services.
- Voucher amount allowing patients to share in the financial savings of cost-reducing shifts.

If competitive approaches are feasible, Urban will develop the demonstration model and an evaluation design. The evaluation will consider:

- Structure of the experimental treatments.
- Methods to ensure randomization.
- Determination of appropriate capitation amounts.
- Design of a reinsurance system.
- Estimate of sample sizes.

Status: The contractor is placing priority on assisting the Health Care Financing Administration in the development of the design and evaluation of a demonstration of a competitive bidding beneficiary incentive model.

Developing Incentive Systems to Increase the Supply of Cadaveric Kidneys for Transplants

Project No.: 14-P-98333/1-01
Period: June 1983 - June 1985
Funding: $ 297,414
Grantee: Brandeis University
Waltham, Mass.
Project Officer: Paul W. Eggers
Division of Beneficiary Studies

Description: Using survey methodologies, this project will evaluate alternative approaches to increasing the participation of nongovernmental actors in organ procurement programs. The end result of the research will be a set of Health Care Financing Administration policy recommendations designed to improve the effectiveness of organ procurement networks and so increase the number of kidneys available for transplantation.

Status: The grant was initiated June 1983.

Case-Mix Differences Between End-Stage Renal Disease Facilities

Funding: Brandeis University Health Policy Consortium
(See page 101)
Project Officer: Paul W. Eggers
Division of Beneficiary Studies

Description: This project examines end-stage renal disease patient characteristics that could impact on facility costs. Using patient history data from the Michigan Kidney Registry, survival analyses were performed to determine predictors of patient outcomes. Patient outcomes will then be correlated with Medicare patient costs.

Status: The patient outcome work has been completed. The cost analysis is entering its final phase. Three papers have been produced.

- "Case-Mix in End-Stage Renal Disease: Differences Between Patients in Hospital-Based and Free-Standing Facilities."
- "An Overview of Case-Mix and Reimbursement."
- "Initial Patient Characteristics and Risk in End-Stage Renal Disease: The Development of Severity Groupings Through a Survival Analysis."

Kidney Procurement in the United States

Funding: Brandeis University Health Policy Consortium
(See page 101)
Project Officer: Paul W. Eggers
Division of Beneficiary Studies

Description: This project examines the organizational and structural characteristics of organ procurement agencies that impact on their ability to procure and supply cadaver kidneys. The project initially examined independent organ procurement agencies and then expanded to hospital-based agencies.

Status: This project has resulted in three papers.

- "Obtaining Replacements: The Organizational Framework of Organ Procurement."
- "Encouraging Altruism: Public Attitudes and the Marketing of Organ Donation."
- "Organizational Effectiveness in Organ Procurement: A Study of Independent Organ Procurement Agencies."

Medicare End-Stage Renal Disease Experience

Funding: Intramural
Project Director: Paul Eggers
Division of Beneficiary Studies

Description: This study examines overall trends in the Medicare end-stage renal disease (ESRD) program. Changes in incidence, prevalence, and patient survival will be explored. In addition, changes in patient characteristics such as age, sex, race, and diagnosis will be documented. Medicare reimbursements for ESRD patients will be analyzed as well, including hospital costs, physician costs, and outpatient dialysis costs. Special analyses will be done on transplant patients.

Status: The following papers and reports have been generated from this study:

- "Life Expectancy and Use of Services by Persons With End-Stage Renal Disease Enrolled in Medicare." Paper presented at the American Public Health Association Annual Meeting, New York, 1979.
- "Analyses of Indicators of Case-Mix Differences Between Free-standing Facility and Hospital-Based Medicare ESRD Patients." Working Paper No. OR-33, Office of Research and Demonstrations, Health Care Financing Administration, May 1982.
- "Trends in Incidence, Prevalence, Survival, and Reimbursement in Medicare ESRD Patients." Working Paper No. OR-40, Office of Research and Demonstrations, Health Care Financing Administration, April 1982.

- "Medicare Program Experience With End-Stage Renal Disease." Paper presented at the New York Academy of Sciences, New York, January 1983.

- "Uses of the End-Stage Renal Disease Medical Information System for Epidemiological Research." Paper presented at the National Nephrology Foundation, New York, January 1983.

- "The Medicare Experience With End-Stage Renal Disease: Trends in Incidence, Prevalence, and Survival." In preparation for the Health Care Financing Review.

- "The Medicare Experience With End-Stage Renal Disease: Trends in Reimbursements." In preparation for the Health Care Financing Review.

- "Cost-Effectiveness of Kidney Transplantation: An Analysis of the Pay-Back Time for Transplant Patients." Paper presented at the 19th National Meeting of the Public Health Conference on Records and Statistics, Washington, D.C., August 1983.

Study of Unentitled End-Stage Renal Disease Patients

Funding: Intramural
Project Director: Brad Perry
Division of Economic Analysis

Description: The Department estimated that in 1981 about 8,500 of the 55,000 End-Stage Renal Disease (ESRD) patients in the United States received dialysis treatments but were not entitled to Medicare benefits. Half of these unentitled patients were awaiting entitlement to the Medicare program. Blue Cross and other private insurers were the major sources of support (50 percent) for ESRD patients awaiting entitlement, while Medicaid was the primary payment source for another 27 percent. The other half of the unentitled patients were not awaiting entitlement because they were not working citizens of the United States (or their dependents) who had contributed to Federal social insurance programs. The major sources of support for 70 percent of these ESRD patients were public programs, that is, Medicaid, Veterans Administration, and State ESRD programs. An estimated 840 kidney transplants were performed on unentitled ESRD patients (about 17 percent of all the transplants performed) in 1981. Medicaid and State ESRD programs were the primary sources for these patients, both for those awaiting entitlement and those not awaiting entitlement. In addition, foreign governments were found to be important sources of payment for transplant patients not awaiting entitlement to Medicare. The costs of extending Medicare ESRD coverage to these unentitled patients were estimated. These costs ranged from $170 million in fiscal year 1984 to $290 million in fiscal year 1988. Since many unentitled ESRD patients were being supported by Federal programs other than Medicare, a decision to extend Medicare coverage to unentitled ESRD patients would reflect a transfer of payment of some of the additional costs from one Federal source to another. On the basis of these findings, the Department recommended that no legislative changes be considered at this time to extend Medicare ESRD coverage to currently unentitled patients with this condition.

Status: The report was completed in March 1983.

Urban Clinics

Urban Health Clinics Demonstration

Project No.: 500-81-0048
Period: September 1981 - December 1985
Funding: $ 891,089
Contractor: SBA/Technassociates, Inc.
Washington, D.C.
Project Officer: John F. Meitl
Division of Health Systems and Special Studies

Description: The Rural Health Clinics Act of 1977 (Public Law 95-210) mandated that the Department of Health and Human Services conduct demonstrations in urban medically underserved areas to test the relative advantages and disadvantages of cost-based and fee-for-service reimbursement for physician-directed clinics that employ physician extenders (physician assistants or nurse practitioners). The demonstration will involve approximately 40 clinics in California and Tennessee. An appropriate definition of medically underserved areas will also be established by the Public Health Service.

Status: The 12-month planning and design phase has been completed. The 2-year operational phase will begin in August 1983. The demonstration will be conducted in Tennessee and California. HCFA's Office of Direct Reimbursement will serve as the fiscal agent for all demonstration clinics. A separate contract for the evaluation was awarded to Arthur D. Little, Inc.

Evaluation of the Urban Health Clinics Demonstration

Project No.: 500-82-0025
Period: September 1982 - March 1986
Funding: $ 806,666
Contractor: Arthur D. Little, Inc.
Cambridge, Mass.
Project Officer: Tony Hausner
Evaluative Studies Staff

Description: The purpose of this contract is to evaluate the Urban Health Clinics Demonstration (Project No. 500-81-0048). The evaluation will focus on use, cost, and quality of services.

Status: The data resources report and literature review were completed January 1983. The research design report and final report were delayed because of delays in implementation of the demonstration. The design report is now scheduled for submission in September 1983 and the final report in March 1986.

Technology Costs

Proposal to Develop a Plan for a Private/Public Sector Entity for Assessing Technology in Medical Care

Project No.: 18-P-98348/3-01
Period: May 1983 - November 1983
Funding: $ 20,000
Grantee: National Academy of Sciences
Institute of Medicine
Washington, D.C.
Project Officer: Brad Perry
Division of Economic Analysis

Description: This grant award to partially support the development of a plan for a private/public entity for the assessment of medical care technologies. The total amount of the grant is $ 133,165, with the Health Care Financing Administration contributing $20,000. A committee of approximately 15 members, appointed by the President of the Institute with the approval of the President of the National Academy of Sciences, will serve as representatives of interested parties, including professional groups, government, private insurance, business, labor, health care institutions, manufacters of health care products, methodological experts, and consumers. The committee is to draft a specific plan for private and pubic sector activity on technology assessment in medical care. The plan would define the mission of the new entity which might be established, identify the composition of the advisory group, outline possible short-term and long-term roles of the Institute, formulate a budget, and suggest mechanisms for support of the continuing effort.

Status: The Presidential Committee has been appointed and has met three times in development of the plan. National Academy of Science staff are currently working on drafts of the report plan and are developing a reports review procedure.

Clinical Social Worker

Medicare Clinical Social Worker Demonstration

Project No.: 500-82-0053
Period: September 1982 - December 1985
Funding: $ 441,345
Contractor: SRI International
Menlo Park, Calif.
Project Officer: Shelagh Smith
Division of Health Systems and Special Studies

Description: The Omnibus Reconciliation Act of 1980 (Public Law 96-499) mandated that the Department of Health and Human Services conduct a demonstration to determine the effects of making the services of clinical social workers more generally available under Medicare. The demonstration will allow direct reimbursement to clinical social workers for their services rather than through a physician or clinic. This contract is for the design and implementation of the direct reimbursement demonstration. There will be a separate contract awarded for the evaluation.

Status: In the initial phase of the project, the contractor has identified the demonstration sites and carriers in each who will process claims and collect information. Southern California is the experimental site and Northern California is the control site. Initiation of services by clinical social workers is planned for Fall 1983. Major tasks planned for the next 6 months are related to administrative claims processing systems to be implemented by the Medicare carrier in the test site, awareness marketing to the clinical social workers and Medicare beneficiaries in Southern California, and a survey questionnaire to clinical social workers in both sites conducted by mail.

Other Coverage

State Policies and Procedures for Determining Medicaid Coverage for Newborns

Project No.: 18-P-97906/5-02
Period: January 1981 - January 1983
Funding: $ 95,339
Grantee: American Academy of Pediatrics
Evanston, Ill.
Project Officer: Judith Sangl
Division of Economic Analysis

Description: This study was done to identify the variety of State Medicaid policies relating to the coverage of newborns and to present realistic options for overcoming the problems created by the current policies. Identifying problematic policies will improve the preventive care available to children eligible for Medicaid.

Status: The first phase of the study has documented the varieties of rules, regulations, and practices that exist among the 50 programs that potentially may deny medical care necessary for newborns or that, in operation, tend to discourage hospitals and physicians from accepting Medicaid patients. The specific rules regarding time and place of application and regulations, such as those requiring billing for services under a newborn's own eligibility number, can act to limit Medicaid coverage of newborns. Within the framework of existing rules, various practices are in operation that may facilitate or prevent the prompt establishment of eligibility. The final report was expected August 1983.

Reexamination of the 44 Freestanding Emergency Centers or Emergicenters

Project No.: 500-82-0027
Period: September 1982 - March 1983
Funding: $ 9,600
Contractor: The Orkand Corp.
Silver Spring, Md.
Project Officer: Benson Dutton
Division of Reimbursement Studies

Description: Performance under this contract consisted of a reexamination of the 44 freestanding emergency centers or emergicenters identified and surveyed in 1979. Efforts were made to contact the management of the original 44 emergicenters. The

contractor attempted to identify and list any newly formed emergicenters. A profile of emergicenters was developed based on observable characteristics. Findings from the new survey will be compared and analyzed with those from the 1979 survey.

Status: Of the 44 emergicenters included in the original study, 12 (27.3 percent) apparently experienced major change in the nature of their operations which resulted in their being dropped from the emergicenter group.

- Two centers closed between 1979 and 1982.
- Three centers were identified as multispecialty clinics or large group practices.
- Seven centers included in the original study were determined to be physician's offices in 1982.

Of the 32 emergicenters that were still in operation in 1982, 10 are hospital affiliated (either owned or managed) and 22 are independent. Twelve of 26 facilities in the followup study reported that they had been in business for 4 years.

Study of Medicare Funded Heart Transplants

Project No.:	500-81-0051
Period:	September 1981 - June 1984
Funding:	$ 1,270,000
Contractor:	Battelle Human Affairs Centers Seattle, Wash.
Project Officer:	Brad Perry Division of Economic Analysis

Description: This project is an evaluation of the scientific, economic, ethical, and social consequences of Medicare coverage for heart transplants. The study will evaluate the survival rates of heart transplant patients and the total costs of transplantation. It will additionally perform an analysis of organ donation, examine the field of organ procurement, and attempt to determine the legal and ethical implications of transplantation while controlling for perceived quality of life. The results will be used to help inform coverage and reimbursement policy.

Status: Participating facilities have been selected. Executive Office of Management and Budget clearance of the survey instruments has been secured. An article that describes the study was published in the November 1982 issue of Heart Transplantation. The Project director has prepared a draft Update Report on the cost of organ procurement and is preparing reports for the Surgeon General's workshop on solid organ procurement.

Determinants of Current and Future Expenditures on Durable Medical Equipment

Project No.: 18-P-97446/1-03
Period: September 1979 - September 1982
Funding: $ 576,219
Grantee: Williams College
Williamstown, Mass.
Project Officer: G. Theodore Saffran
Division of Health Systems and Special Studies

Description: This 3-year research project was initiated to analyze the structure, conduct, and performance of the durable medical equipment (DME) industry. In addition, a model of the demand for durable medical equipment was constructed for the purpose of predicting future expenditures by the Health Care Financing Administration (HCFA) for such items as wheelchairs, hospital beds, etc. The feasibility of rental or purchase of equipment items, in view of economic, medical, or other evidence was also examined.

Status: The final report was completed in April 1983. Williams examined program expenditures, the supplier industry, and the reasonable charge screen process in an analysis of the demand and supply characteristics of the DME market. Among the findings are the following:

- Medicare Part B expenditures for 1982 were approximately $310 million, with an annual growth rate of 20 percent.
- The majority of retail suppliers are single location owner-operated businesses not affiliated with a franchise operation, although mergers, acquisitions, and franchises are increasing.
- Rental rates are established through the application of rules of thumb typically 1/10 of the suggested retail price as established by the manufacturer.
- Purchase prices are established by using the suggested retail price of the manufacturer.
- Purchase decisions are influenced by age, sex, income level, and education.
- The retail durable medical equipment industry's profitablility, as measured by the rate of return on assets, is aout 14 percent.
- During periods of high inflation (7 percent and above) the reasonable charge screens have reduced expenditures for the Medicare program and its beneficiaries.

Medicare Mental Health Demonstration

Project No.: 500-80-0046
Period: July 1980 - July 1983
Funding: $ 736,000
Contractor: Executive Resource Associates
Arlington, Va.
Project Officer: Melvin Bulkley
Division of Health Systems and Special Studies

Description: This demonstration tests the cost effectiveness and impact of expanded Medicare coverage of outpatient mental health services provided in freestanding community mental health centers and partial hospitalization facilities. Services provided by nonphysician mental health professionals are covered, beneficiary cost-sharing requirements are relaxed, and reimbursement is made on a cost-related basis. The contract provides technical assistance in the implementation and monitoring of the demonstration requirements in the 40 participating facilities.

Status: Near the end of its operational phase, 7,000 beneficiaries had received services and $9 million had been paid to the facilities for these services. The implementation contractor made two visits to each facility to verify that they were complying with requirements. Utilization had increased, especially for beneficiaries 65 years of age and over and beneficiaries with no previous mental health treatment. A separate contract for the evaluation was awarded to Macro System, Inc.

Evaluation of the Medicare Mental Health Demonstration

Project No.: 100-80-0148
Period: September 1980 - June 1984
Contractor: Macro System, Inc.
Silver Spring, Md.
Co-Project Officers: Sharman Stephens
Office of the Assistant Secretary for Planning and Evaluation, DHHS
Tony Hausner
Evaluative Studies Staff

Description: This project evaluates the utilization and cost implications of a demonstration encompassing 40 sites that waives the physician supervision requirements for Medicare reimbursement to mental health centers. Study areas will focus on assessment of impact of this waiver on mental health services, utilization patterns, overall cost to the Medicare program, and administrative and operational capacity of the participating mental health centers. The Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, is funding this project and administering it jointly with the Health Care Financing Administration.

Status: The research design was completed in August 1981, and the study is underway. A final report is expected in December 1983, and a supplementary report in June 1984.

Study of the Impact of Rural Health Clinics on the Use of Inpatient Hospital Services

Project No.: 18-P-98061/1-02
Period: August 1981 - August 1983
Funding: $ 118,881
Grantee: Medical Care Development, Inc.
Augusta, Maine
Project Officer: John Petrie
Division of Reimbursement Studies

Description: This study will determine the impact on inpatient hospital use and expenditures of increased access to primary care in areas served by federally funded rural health clinics (RHC's). The researchers expect to learn whether RHC care serves as a substitute for inpatient care, thereby reducing total medical costs of patients in rural communities, or as a complement to inpatient care, thereby increasing these patients' medical costs.

Status: Medical Care Development has selected target and control areas for the study and secured and coded three sets of data: RHC encounter data, hospital discharge data, and Maine population data. Preliminary findings indicate that the use of inpatient hospital services by Medicare beneficiaries (and inpatient hospital expenditures for these beneficiaries) may be higher in areas served by RHC's, compared with rural areas not served by RHC's. More comprehensive findings and a final report are expected by February 1984.

Study to Evaluate the Impact of Rural Health Clinic Services

Project No.: 18-P-97625
Period: July 1980 - June 1983
Funding: $ 416,515
Grantee: University of Washington
Department of Health Services
Seattle, Wash.
Project Officer: Alan Friedlob
Evaluative Studies Staff

Description: The project goal is to assess the contribution of the Rural Health Clinics Act of 1977 (Public Law 95-210) to the development and function of rural health clinics. The study focuses on examining rural health clinics in Idaho and Washington. The study evaluates the use of rural health clinics in these two States by Medicaid beneficiaries and through application of tracer disease methodology, and focuses on the treatment costs for common illnesses at rural health clinics, compared with noncertified clinics and physicians' offices.

Status: A final report will be available by October 1983.

California State Copayment Project

Project No.: 11-P-98206/9-02
Period: March 1982 - March 1985
Grantee: California Department of Health Services
Sacramento, Calif.
Project Officer: John F. Meitl
Division of Health Systems and Special Studies

Description: The purpose of this project is to determine if nominal copayments will reduce inappropriate use of health services while not affecting needed services. Copayments are limited to ambulatory services and are collected by the provider. Early and Periodic Screening, Diagnosis, and Treatment eligibles and Medicare beneficiaries are exempt from all copayments. Copayments are, with some exceptions: $1 for each outpatient, clinic, or physician-type visit; $5 for each visit for nonemergency services received in an emergency room; and $1 for each drug prescription.

Status: The demonstration was implemented on May 10, 1982. Data will be available for evaluation after September 1983. The emphasis under the grant will change from implementation to evaluation activities.

Medigap Study of Comparative Effectiveness of State Regulations

Project No.: 500-81-0050
Period: September 1981 - December 1983
Funding: $ 1,258,757
Contractor: SRI International
Menlo Park, Calif.
Project Officer: Judith Sangl
Division of Economic Analysis

Description: This study will evaluate the effectiveness of various State regulatory approaches for health insurance sold to the elderly. It contains both a consumer survey of Medicare beneficiaries and an industry survey of the companies who sell insurance to them. It will be conducted in six States.

Status: The draft report of the consumer survey was submitted in June 1983. The report found that three State actions appear to result in the purchase of higher quality policies. They are:

- Establishing miminum benefit requirements.
- Setting mimimum loss ratios.
- Distributing consumer guides.

Although, State regulations seem to have less impact on sales abuse, two strategies--distributing consumer guides and issuing press releases when companies or agents are found guilty of misrepresentation--appear to have some beneficial effect.

Finally, the distribution of consumer guides was associated with greater consumer knowledge of Medicare or of the policies purchased. The final report of the consumer survey will be available in Fall 1983. Data collection for the industry survey began in June 1983 and the final report is expected in December 1983.

Technology Assessment for Insurance Coverage Decisions

Funding: Brandeis University Health Policy Consortium
(See page 101)
Project Officer: Allen Dobson
Office of Research

Description: Massachusetts Institute of Technology (MIT), a part of the University Health Policy Consortium, has undertaken a two-part study involving technology assessment for insurance coverge decisions. The first part of the study looks at the decisionmaking process used by the National Center for Health Services Research regarding Medicare coverage of new technologies. Two samples of technological innovations have been drawn. The first consists of 11 procedures that are being studied in depth. The second sample consists of 51 procedures less intensively studied. The second part of the study is to identify the factors and weights related to the coverage decisions and to examine how they influence the coverage recommendations.

Status: The study is nearing completion. A draft report of the findings is being completed and will be submitted when the grant ends.

Alcoholism Services Demonstration Projects

Period: September 1981 - December 1985
Project Officer: Andrew K. Solarz
Division of Health Systems and Special Studies

Description: The following six projects are a collaborative demonstration between the Office of Research and Demonstrations, Health Care Financing Administration, and the National Institute on Alcohol Abuse and Alcoholism, Public Health Service. These demonstration projects are designed to test the feasibility and cost effectiveness of providing limited coverage for alcoholism treatment services given in freestanding (nonhospital) treatment centers. Each project is uniformly using the following service limits for Medicare and/or Medicaid services:

- Alcohol detoxification - No limit on episodes.
- Inpatient treatment - Up to 30 days per year.
- Outpatient treatment - Up to 45 visits per year.
- Halfway houses - If qualified, can render all of the above services.

Alcoholism Services under Medicaid: Connecticut Demonstration

Project No.: 95-P-97968/1-02
Funding: $ 324,789
Grantee: Connecticut Alcohol and Drug Abuse Commission
Hartford, Conn.

Status: Coverage of services in Connecticut was initiated July 1, 1982. The State has 12 providers participating in the demonstration in Medicare only. Provider staff has been trained in billing and cost-reporting procedures. A beneficiary and referral centers demonstration awareness program has been developed within the target area. The continuation application for the second year has been approved.

Alcoholism Services under Medicare and Medicaid: Illinois Demonstration

Project No.: 95-P-97971/5-02 (Medicare)
Funding: $ 159,739
Grantee: Department of Mental Health and Developmental Disabilities
Springfield, Ill.

Project No.: 11-P-97972/5-02 (Medicaid)
Funding: $ 182,000
Grantee: Department of Public Aid
Springfield, Ill.

Status: Coverage of services in Illinois was initiated July 1, 1982. The State has nine providers participating in the demonstration in both Medicare and Medicaid. Provider staff has been trained in billing and cost-reporting procedures. A beneficiary and referral centers demonstration awareness program has been developed within the target area. The continuation application for the second year has been approved. Illinois has developed a prospective rate for alcoholism services that will be used in the project.

Alcoholism Services under Medicare and Medicaid: Michigan Demonstration

Project No.: 95-P-97975/5-02 (Medicare)
Funding: $ 59,053
Grantee: Office of Substance Abuse Services
Department of Public Health
Lansing, Mich.

Project No.: 11-P-97976/5-02 (Medicaid)
Funding: $ 277,346
Grantee: Medical Services Administration
Department of Social Services
Lansing, Mich.

Status: Coverage of services in Michigan was initiated July 1, 1982. The State has 22 providers participating in the demonstration in both Medicare and Medicaid. Provider staff has been trained in billing and cost-reporting procedures. A beneficiary and referral centers demonstration awareness program has been developed within the target area. The continuation application for the second year has been approved.

Alcoholism Services under Medicare and Medicaid: New Jersey Demonstration

Project No.: 99-P-97973/2-02
Funding: $ 416,340
Grantee: Division of Medical Assistance and Health Services
Trenton, N.J.

Status: Coverage of services in New Jersey was initiated August 1982 for Medicare and in October 1982 for Medicaid. The State has 14 providers participating in the demonstration in both Medicare and Medicaid. Provider staff has been trained in billing and cost-reporting procedures. A beneficiary and referral centers demonstration awareness program has been developed within the target area. The continuation application for the second year has been approved.

Alcoholism Services under Medicare and Medicaid: New York Demonstration

Project No.: 99-P-97979/2-02
Funding: $ 403,383
Grantee: Division of Medical Assistance
Department of Social Services
Albany, N.Y.

Status: Coverage of services in New York was initiated July 1, 1982. The State has 12 providers participating in the demonstration in both Medicare and Medicaid. Provider staff has been trained in billing and cost-reporting procedures. A beneficiary and referral centers demonstration awareness program has been developed within the target area. The continuation application for the second year has been approved.

Alcoholism Services under Medicare: Oklahoma Demonstration

Project No.: 95-P-97983/6-02
Period: September 1981 - December 1985
Funding: $ 600,000
Grantee: American Indian Institute
University of Oklahoma
Norman, Okla.

Status: Coverage of services in Oklahoma was initiated July 1, 1982. The State has 13 providers participating in the demonstration in Medicare only. Provider staff has been trained in billing and cost-reporting procedures. A beneficiary and referral centers demonstration awareness program has been developed within the target area. The continuation application for the second year has been approved.

Evaluation of the Alcoholism Services Demonstration

Project No.: 500-83-0023
Period: April 1983 - December 1986
Funding: $ 2,644,996
Contractor: Lawrence Johnson and Associates, Inc.
Washington, D.C.
Project Officer: Tony Hausner
Evaluative Studies Staff

Description: This is an evaluation of the effectiveness of the demonstration that expands Medicare and/or Medicaid coverage to free-standing alcoholism treatment centers. It will examine the impact of the demonstration on the use and cost of services. The project is supported by funds from the National Institute on Alcohol Abuse and Alcoholism, Public Health Service, and the Health Care Financing Administration.

Status: The research design was completed in March 1983. The contractor is currently implementing the research design. Data collection, analysis, and submission of interim and final reports will follow. The final report is due December 1986.

Obstetrical Access Pilot Project

Project No.: 11-P-97223/9-03
Period: July 1979 - March 1983
Grantee: Department of Health Services
Sacramento, Calif.
Project Officer: Andrew K. Solarz, Ph.D.
Division of Health Systems and Special Studies

Description: This project has tested the hypothesis in 10 clinical sites that the provision of early access to obstetrical services for low-income pregnant women would reduce subsequent morbidity of both infants and mothers. Services included health education, nutrition, and psychosocial assessments in addition to prenatal, delivery, and postpartum services. They comprised prenatal services not otherwise reimbursed under the Medi-Cal program, but provided in this pilot project.

Status: The demonstration phase of this project came to a close on March 31, 1983, however, the processing of claims data is continuing. More than 6,000 claims have been completed; about 600 are outstanding. The evaluation of the data, under a separate Health Care Financing Administration contract, will continue through 1983; an evaluation report is expected in early 1984.

Evaluation of Obstetrical Access Pilot Project

Project No.: 11-P-97578/9-03
Period: March 1980 - December 1983
Funding: $ 203,370
Grantee: Department of Health Services
Sacramento, Calif.
Project Officer: Tony Hausner
Evaluative Studies Staff

Description: The purpose of this grant is to conduct an evaluation of the Obstetrical Access Pilot Project (Project No. 11-P-97223/9-03).

Status: The research design was completed in December 1981. An interim report was prepared in December 1982 for submission to the State legislature. A key finding is that the project reduced the rate of low-birthweight babies. The final report is expected in December 1983.

Foot Care Coverage Study

Funding: Intramural
Project Director: William J. Sobaski
Division of Reimbursement Studies

Description: Public Law 96-499, Section 958 (g), directs the Secretary to conduct a study involving a comprehensive analysis of the cost effects of alternative approaches to improving coverage under Title XVIII of the Social Security Act for the treatment of various types of foot conditions. The study has involved meetings and discussions with professional and Federal experts; staff reviews of literature and relevant statistical information; a Federal Register notice soliciting information and comments from the public; a survey of State Plans for Medical Assistance; an independent study by the Center for Health Services and Policy Research at Northwestern University; and actuarial estimates of the costs of eliminating certain presently excluded or specially restricted types of expenses for treatment of foot conditions. The study will examine present Medicare benefits for the treatment of foot conditions as specified in the law and its implementing regulations and manuals. Possible ways for improving coverage will be identified, and the effects these changes could have upon beneficiary health status and on the pattern of sources now used for financing foot care treatment will be considered.

Status: The report is under development and should near completion by Spring 1984.

Registered Dietitians in Home Care

Funding: Intramural
Project Director: Mildred Corbin
Office of Research

Description: Section 958 of Public Law 96-499, the Omnibus Reconciliation Act of 1980, directs the Department of Health and Human Services to conduct a study of "the circumstances and conditions under which services furnished by registered dietitians should be covered as a home health benefit under Title XVIII of the Social Security Act." The study has three objectives:

- To assess Medicare beneficiaries' needs for direct clinical counseling by registered dietitians in the home.
- To explore alternative methods for coverage and reimbursement.
- To estimate utilization rates and costs for the alternative methods of coverage and reimbursement.

Status: The draft report is currently under review by the Health Care Financing Administration. It is due to be submitted to the Secretary of the Department of Health and Human Services by Fall 1983.

Home Respiratory Therapy Services

Funding: Intramural
Project Director: Marni Hall
Division of Economic Analysis

Description: Section 958 of Public Law 96-499, the Omnibus Reconciliation Act of 1980, requires that the Department of Health and Human Services (DHHS) conduct "a study of the circumstances and conditions under which services furnished with respect to respiratory therapy should be covered as a home health benefit under Title XVIII of the Social Security Act." This study evaluates these issues and examines the present "state of the art" in respiratory therapy and the current availability of respiratory therapy services. It also examines the medical and economic ramifications of expanding Medicare benefits to include those home services provided by respiratory therapists.

Status: The draft report is currently under review by the Health Care Financing Administration. It is due to be submitted to the Secretary of the Department of Health and Human Services in Fall 1983.

Medicare Health Maintenance Organization Additional Benefits

Funding: Intramural
Project Director: Marni Hall
Division of Economic Analysis

Description: Section 114 of Public Law 97-248, the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), requires that, to the extent a health maintenance organization's (HMO) Medicare payment exceeds its adjusted community rate under a risk-sharing contract, the HMO must use the savings to provide its Medicare members additional benefits or reduced cost sharing. Section 114 also requires that the Secretary conduct a study of the additional benefits provided under this provision. This study will report on the number of HMO's subject to the additional benefits requirement, and the nature of the benefits that HMO's choose to provide.

Status: The study depends on data that will be collected in 1984. This information will be compiled in a report due to Congress in August 1985.

Child Health

Health Care Services for Children Under Medicaid

Project No.: 18-P-98011/3
Period: August 1981 - September 1983
Funding: $ 425,605
Grantee: John Hopkins University
School of Medicine
Department of Pediatrics
Baltimore, Md.
Project Officer: Benson Dutton
Division of Reimbursement Studies

Description: The Health Care Financing Administration approved a grant for a comparative study of health care services for children by using billing claims and eligibility data files from the State of Maryland. The grantee seeks information on the cost and effectiveness of services for children eligible for the Medicaid Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT). Data on the costs and utilization of services for children using private practitioners, hospital clinics, emergency rooms, and various combinations of delivery systems serve as the bases for this analysis.

Status: Accomplishments to date include:

- Meetings with State Medicaid agencies.
- Completion of preliminary analysis of Children and Youth Project data, and records of eligibility for input into the data base.
- Acquisition of eligibility tape files.
- Conversion of eligibility tape files and payment files.

Prenatal Care and Its Relationship to Medicaid Costs

Project No.: 18-P-98305/7-01
Period: March 1983 - March 1985
Funding: $ 55,972
Grantee: Missouri Division of Health
Jefferson City, Mo.
Project Officer: Benson Dutton
Division of Reimbursement Studies

Description: This project links birth certificate records with Medicaid obstetrical and newborn records. The combined data set will be used to study the obstetrical and newborn Medicaid costs associated with women who receive preventive prenatal

services as opposed to those who do not receive adequate services. The primary goal of the project is to determine if the Medicaid coverage provided for Medicaid mothers obtaining adequate prenatal care is cost beneficial.

Status: This project was initiated March 31, 1983.

Other Prevention

Municipal Health Services Program

Project No.: Cooperative Agreement
Period: August 1979 - December 1984
Participants: Baltimore, Md.
Cincinnati, Ohio
Milwaukee, Wis.
St. Louis, Mo.
San Jose, Calif.
Project Officer: Shelagh Smith
Division of Health Systems and Special Studies

Description: Municipal Health Services Program (MHSP) is a collaborative effort of five major cities in five States, the U.S. Conference of Mayors, the Robert Wood Johnson Foundation (RWJF), and the Health Care Financing Administration (HCFA). It was initiated by RWJF through grants of $3 million awarded in June 1978 to each of the following five cities: Baltimore, Cincinnati, Milwaukee, St. Louis, and San Jose. HCFA joined in the project by providing Medicare waivers through a cooperative agreement and Medicaid waivers to test the effects of increased utilization of municipal health centers by:

- Eliminating coinsurance and deductibles.
- Expanding the range of covered services.
- Paying the cities the full cost of delivering services at the clinics.

The intent of the waivers is to shift fragmented utilization away from costly hospital emergency rooms and outpatient departments toward lower cost Municipal Health Services Program (MHSP) clinics which would provide beneficiaries with comprehensive, primary and preventive health care.

Status: The first city began billing under the Medicare waiver in August 1979. Four of the five cities (all except Cincinnati) desired to use Medicaid waivers as well, and this brought in participation of the State Governments in 1981. As of January 1982, the five MHSP cities have a total of 19 clinics operating, bringing together both public and private health-related organizations. A wide variety of services are offered, including medical, social, mental, preventive, dental, optometry, podiatry, and rehabilitation. Clinic utilization ranges widely from 700 visits per year to 40,000 visits per year. Average provider productivity ranges from 3,200 to 4,500 annual visits per full-time equivalent provider.

Evaluation of Muncipal Health Services Program

Project No.: 500-78-0097
Period: September 1978 - March 1984
Funding: $ 3,105,250
Contractor: University of Chicago
Chicago, Ill.
Project Officer: Tony Hausner
Evaluative Studies Staff

Description: This is an evaluation of the Municipal Health Services Program demonstrations. It is a collaborative effort with the Robert Wood Johnson Foundation. The evaluation covers the quality and efficiency of services delivered in urban clinics in five cities (Baltimore, Cinncinati, Milwaukee, St. Louis, and San Jose).

Status: The contractor has submitted interim reports covering the baseline survey and secondary data resources. The final report, which will include data from the followup survey, is expected in March 1984.

Quality and Effectiveness of Preventive Medical Care

Project No.: 18-P-97777/9
Period: September 1980 - March 1984
Funding: $ 596,804
Grantee: Rand Corporation
Santa Monica, Calif.
Project Officer: Benson Dutton
Division of Reimbursement Studies

Description: This study focuses on the effect of preventive care on various categories of medical expenditure and any losses attributed to sickness. Issues and questions to be addressed include:

- The effects of preventive care on health status, medical care use, and work time available.
- The responsiveness of consumer demand to changes in the price of preventive care.
- The amounts of preventive care used in prepaid systems versus fee-for-service practice settings, both with no out-of-pocket charges.
- Whether or not people choosing the prepayment plan are fundamentally different in their desires to obtain preventive care.

The study will use data from the Rand Health Insurance Study (HIS), a social experiment in which families are assigned to several different health insurance plans. Approximately 8,000 individuals have been enrolled at six sites across the country: Dayton, Ohio; Seattle, Washington; Fitchburg, Massachusetts; Franklin County, Massachusetts; Charleston, South Carolina; and Georgetown County, South Carolina.

Status: The tasks for the 3-year study include the following. During the first year, working knowledge of the relevant HIS data will be developed; computer programs will be constructed; literature review undertaken; and the analytic design will be refined. In the second year, analyses will be performed on the Dayton, Seattle, and Fitchburg/Franklin 3-year sample data; and the analytic design and computer software further developed. The third year will be spent extending the analysis to the 5-year samples, further developing the analytic design, and preparing reports. Expectations are that the study will produce a fairly detailed and complete picture of the causes of preventive care expenditures and the consequences for health outcomes, and acute and chronic medical care expenses.

Evaluation of the Impact of Second Opinions for Elective Surgery

Project:	500-78-0047
Period:	September 1978 - September 1983
Funding:	$ 2,225,791
Contractor:	Abt Associates, Inc. Cambridge, Mass.
Project Officer:	Alan Friedlob Evaluative Studies Staff

Description: The objective of this evaluation is to determine the effect of formal second opinion programs on surgery rates, surgical costs, and the health of patients who forgo surgery as a result of obtaining a second opinion. The basis of the evaluation is two voluntary Medicare Second Surgical Opinion Programs (SSOP) in New York City and Detroit, the State of Massachusetts' mandatory Medicaid SSOP, and the Health Care Financing Administration's (HCFA) public information second surgical opinion program.

Status: A major report has been produced. Based on this report, the Office of Research and Demonstrations, HCFA, prepared a report to Congress on the desirability of waiving Medicare cost-sharing for voluntarily sought second surgical opinions. This study is summarized in a brief report in the September 1982 issue of the Health Care Financing Review. A survey of 445 Medicare beneficiaries in New York City--both voluntary program users and control group beneficiaries (who were recommended for select procedures but who did not use the program)--has been completed. Five papers analyzing this data are in preparation and expected to be completed by October 1983.

Cooperative Health Education Project

Project No.:	18-P-97191/3-03
Period:	February 1980 - January 1983
Funding:	$ 261,245
Grantee:	Center for Consumer Health Education Vienna, Va.
Project Officer:	Shelagh Smith Division of Health Systems and Special Studies

Description: The Cooperative Health Education Project is a large, quasi-experimentally designed project that investigates the impact of several levels of educational interventions on utilization of prepaid health care services and on individual health risk behaviors. The interventions emphasize self-care and self-responsibility for

health. Printed materials (books and newsletters on health and self-care), a telephone information service, and a conference with a nurse practitioner are the major interventions used. The project is implemented at two health maintenance organizations: Prime Health in Kansas City, Mo., and Rhode Island Group Health Association in Providence, R. I.

Status: The draft final report has been received and revealed significant decreases (14 percent) in utilization of ambulatory services on the part of the experimental group. Some additional analysis is being conducted with the data on the Medicare group alone.

Prevention of Future Utilization of Health and Long-Term Care Services

Project No.: 18-P-98288/3-01
Period: March 1983 - March 1986
Funding: $ 737,000
Grantee: Johns Hopkins University
School of Hygiene and Public Health
Baltimore, Md.
Project Officer: Shelagh Smith
Division of Health Systems and Special Studies

Description: Johns Hopkins is evaluating an intervention project conducted at New York University Hospital, entitled "Cooperative Care" in which chronically ill Medicare beneficiaries and their care partners are trained in self-care techniques. The purpose of the project is to reduce the high rate of post-discharge rehospitalizations for certain chronic conditions, e.g., heart disease, through good home care monitoring. Cooperative care, a 4-day inpatient education program, emphasizes the care partner's role in reinforcing patients to take their medication and to adhere to diet and exercise regimens.

Status: Since the beginning of the study (1979), 480 patients plus 480 care partners have been randomly assigned to the experimental or control group. Approximately 80 percent of the experimental patients are transferred into Cooperative Care from New York University Hospital, and the other 20 percent are directly admitted to the program. Half of the patients in the study have completed the first followup questionnaire (2 weeks), and more than a third more have completed the 6-month followup questionnaire.

Trends in Pediatrician Participation in State Medicaid Programs

Project No.: 18-P-98265/5-01
Period: March 1983 - September 1984
Funding: $ 195,796
Grantee: American Academy of Pediatrics
Evanston, Ill.
Project Officer: Benson Dutton
Division of Reimbursement Studies

Description: The overall goal of the proposed study is to measure and analyze trends in physician participation in Medicaid and the early periodic screening, diagnosis, and treatment (EPSDT) in the 13 States that were studied by the Health Care Financing Administration in 1979. The study will also identify and recommend State-specific

policy strategies for fostering the participation of primary care physicians in Medicaid, thereby promoting access of children to appropriate and efficient sites of preventive and acute care.

Status: This project was initiated March 31, 1983.

INDEX TO CONGRESSIONALLY MANDATED STUDIES

AFDC Home Health (Public Law 96-499) 55

Clinical Social Workers (Public Law 96-499) 120

ESRD Medicare Coverage (Public Law 95-292) 118

Fixed-Price Contracting (Public Law 92-603) 95

Foot Care (Public Law 96-499) 132

Hospice Care (Public Law 97-248) 33

HMO Additional Benefits (Public Law 97-248) 133

Medigap (Public Law 96-265) 126

Physician Prospective Payment (Public Law 98-21) 25

Registered Dietitians (Public Law 96-499) 132

Respiratory Services (Public Law 96-499) 133

Swing Beds (Public Law 96-499) 49

Urban Health Clinics (Public Law 95-210) 119

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
OFFICE OF RESEARCH AND DEMONSTRATIONS
6325 SECURITY BLVD.
BALTIMORE, MARYLAND 21207

OFFICIAL BUSINESS
PENALTY FOR PRIVATE USE, $300

U.S. Department of Health and Human Services
Health Care Financing Administration
Office of Research and Demonstrations
HCFA Pub. No. 03165 October 1983